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Christine Brydon

‘Head-Hunting’ (or Grief Management) on Teesside

Pregnancy Loss and the Use of Counselling as a Ritual in the Resolution of Consequential
Grief.

Master of Arts Degree by Thesis

University of Durham

Department of Anthropology

2001

Abstract

This anthropological thesis is based on an evaluation carried out at South Cleveland Hospital on Teesside, where midwives offer counselling to bereaved parents following pregnancy loss. Both quantitative and qualitative methodologies are utilised in the form of individual case studies, patient focus groups, and a standardised questionnaire distributed to medical professionals. The purpose of the evaluation is to ascertain the efficiency and efficacy of the service, the advantages or disadvantages of the service being administered by midwife/counsellors, and how any subsequent service might be improved upon. Given the fact that pregnancy loss was considered linguistically taboo until only a few years ago, the anthropological interest in the study examines the shift in emotional reaction to pregnancy loss in western culture and the role of counselling in grief management following a loss. The work draws upon the expertise of several authors who have written on the issues concerning historical and cross cultural characteristics of pregnancy loss, the therapeutics of counselling in grief management, embodiment, narrative theory, performance, and the use of ritual in the creation of new social and cultural practices. It is concluded from the study that counselling is a ritual of post-modern times, the efficacy of which might depend upon clients’ opportunity to ‘perform’ a ritual of any kind, rather than on the qualities inherent in a specific ritual such as counselling or headhunting, in accordance with Rosaldo (1993;4-6).

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'Head-Hunting' (or Grief Management) on Teesside

Pregnancy Loss and the Use of Counselling as a Ritual

in the Resolution of Consequential Grief

Submitted by

Christine Brydon

Master of Arts Degree by Thesis

University of Durham

Department of Anthropology

2001



17 MAY 2002

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Acknowledgements

The completion of this thesis is entirely due to the help, support, and encouragement I have received from the following people to whom I am most grateful. Dr. I. R. Edgar, the midwife/counsellors and other staff and patients of the Division of Women and Children at South Cleveland Hospital, the respondents who took part in the study by Email, Mary Holcroft, my husband, family and friends, Douglas Ashby, and Vicky Brewer.

Definitions

Stillbirth means a child that has issued forth from its mother after the twenty fourth week of pregnancy and which did not at any time after being completely expelled from its mother, breathe or show any other signs of life (Royal Alexander Hospital 1998:South Cleveland Hospital 1999).

Abortion is the medical term for the death or expulsion of a foetus either spontaneously by miscarriage or by induction before the twenty fourth week of pregnancy. (Royal Alexander Hospital 1998:South Cleveland Hospital 1999).

Termination of pregnancy (TOP) for foetal abnormality (also known as therapeutic abortion) is the termination of pregnancy when there is substantial risk to the health of a mother or that a child would suffer from mental or physical abnormalities as to be seriously handicapped (Mander 1994).

'Head-Hunting' (or Grief Management) on Teesside

Pregnancy Loss and the Use of Counselling as a Ritual in the Resolution of Consequential Grief

Introduction

The Complexities of Pregnancy Loss and Counselling

Although pregnancy loss is an inevitable characteristic of life it is only in recent years that anthropologists have given any attention to the social significance of this event (Kohn & Moffitt 1994; Inhorn 1994). This might seem rather surprising when pregnancy loss is linked so closely to reproduction, birth, death, funerary rites and embodiment, themes that are the substance of several anthropological studies (Cecil 1996:1). However, pregnancy loss appears to be more complex than most other life issues, infringing as it does upon sex, birth and death, all subjects that are regarded as polluting and profane in many cultures because of their association with sex fluids, blood, and the corpse (Douglas 1966:176). But when we consider how pregnancy loss is dealt with 'or not dealt with' in our own society, the reason for the scarcity of anthropological literature appertaining to the social significance of the event becomes self-explanatory. Here in the West pregnancy loss is usually only considered in a clinical setting and the narrative of our culture makes little provision for the social aspects of this totally natural event to be dealt with in a dignified and socially acceptable manner. Those afflicted by failed pregnancy have until recently suffered in silence. The justification for this silence appears in part to be rooted in the past when women were accused by society of 'doing away with' unwanted pregnancies. The finger of suspicion was pointed at any woman who reported the occurrence of a stillbirth or miscarriage unless she could prove that the baby had been born dead (Donninson 1988:17).

Although women are no longer overtly accused of misconduct when a pregnancy fails, western culture has not yet replaced this antediluvian response with one that supports women who already feel humiliated by their failure to reproduce (Kohn & Moffitt 1994; Mander 1994). According to Becker (1997: 81-83), prior to a disruption in bodily function people give little attention to the body as they go about their daily lives but once the body begins to function differently to what is deemed 'normal' by the standards of



society, it becomes the focus of identity and unknown terrain must be negotiated. Numerous sentiments and emotions affect women who cannot bear children, ranging from rage, guilt, shame, grief and remorse, to the inevitable feelings of inadequacy and self-reproach. “If you don’t have a child, there’s something wrong with you mentally or ‘you’re a witch, you’re bad, there’s something you did and are being punished for (interview with Martina; Becker 1997:82).”

When pregnancy does not result in the birth of a normal healthy baby it raises many issues, not only for those directly concerned with the loss but also for society as a whole. Expectant parents are not prepared psychologically for what is obviously a possible outcome to any pregnancy, since the majority of media coverage of childbirth is concerned only with the normal process of conception and its perfect outcome. Society too finds the situation difficult to cope with and even friends and family either avoid parents who have suffered a loss, usually to conceal their own embarrassment because they have no idea of how to approach the situation, or they make wild presumptions about what the woman might have done to cause the loss to happen. Because many women feel unsupported by family and stigmatised by society following pregnancy loss, some are now seeking support from professional counsellors and psychotherapists to help them cope with the emotional and social torment that often accompanies failed pregnancy (Kohner & Henley 1991). And despite the fact that some social scientists and health professionals question the legitimacy of counselling as a therapy, suggesting it could do more harm than good (Giddens 1991; Charlton 1998), counselling is now evolving into one of the major growth industries of our time (Hodgkinson 1992).

Although an exact understanding of the fundamentals of counselling is difficult to grasp, because there are many different approaches to counselling that include a whole range of activities and situations, it is in essence described as a performance where counsellors encourage clients to dramatise their grief in order to create new meaning of their experiences (Lindquist 1997:110; Edgar 1995:6; Jennings 1992). Turner (1987) maintains that all humans are performers and that it is through the enactment of life events that we learn more about ourselves. Since counselling is a type of performance and its reputed effects share similarities with those of ritual practices cross-culturally, in as much as ritual is said to bring about a change of consciousness in its participants (Mattingly

1988), it is proposed in this study that counselling is a ritual of post-modern times. However, just as there are a multitude of explanations as to what counselling is and how it might influence participants there are also numerous hypotheses as to what constitutes a ritual. While Turner (1967:19) maintains that a peculiarity of ritual is its reference to mystical beings of power, many other anthropologists, sociologists, and psychologists contend there is a ‘secular’ aspect to ritual that makes no allusion to supernatural forces, and that rituals are performed in all sectors of society on a daily basis (Humphries & Laidlaw 1994:71).

On the other hand Rosaldo (1993:4) suggests that the exact nature of ritual is not the most important issue when assessing the significance of ritual. After a reassessment of his fieldwork carried out among the Ilongot head-hunters of the Philippines, Rosaldo declares that contrary to his former belief, that it is the ‘specific’ ritual of head-hunting that aids in the management of rage and grief for the Ilongot, he is now of the opinion that the performance of ‘any’ ritual might be as effective in grief management since it is the powerlessness to perform rituals that creates anxiety. Hence the title of this work! Nevertheless, counselling does not work for everyone and Mattingly (1998:107) suggests it is the need to locate a ‘desire’ to find a new course or *telos* in life that is accessed during counselling that makes a difference to the outcome, and not merely the creation of a new meaning for a client’s experience.

This work is a study of the social issues surrounding pregnancy loss and the use of counselling as a means of resolving consequential grief. It is based on an evaluation of the counselling service at South Cleveland Hospital, Teesside, which is offered to women who experience miscarriage, stillbirth or termination for foetal abnormality. The study came into being after midwives and managers at South Cleveland Hospital requested that an evaluation of the counselling service be carried out to clarify the following points; the need and efficiency of the counselling service at the hospital; possible areas for improvement to the service; and the therapeutic and financial value of the dual role of midwife/counsellor in cases of pregnancy loss.

The development of the counselling service at the hospital was a response to Government recommendations following the ‘*Changing Childbirth Report*’ of 1993 where it was

advised that the nature of medical procedures adopted during pregnancy and also the level of after-care that women receive following childbirth should be revised. Midwives working in the ‘Division of Women and Children’ at South Cleveland Hospital believe that they are providing an improved continuity of care for all post-natal women, and especially for those who have unproductive pregnancies by offering them the facility of the counselling service. However, many health professionals are not convinced that counselling is of benefit to these patients since there is no scientific evidence to support the claims of counsellors who assert that counselling can bring about the resolution of grief in some patients.

Because pregnancy loss is a highly emotive issue and the welfare of patient/respondents is of paramount importance, the format of the evaluation was under the authority of the hospital ethics committee. The content and context of questions presented to respondents during interviews were carefully thought out and scrutinised by the ethics committee to ensure that respondents would not be unduly distressed. The report on the findings of the evaluation that was presented to the hospital addresses mainly the need and effectiveness of the counselling service and is included in this work throughout chapters four, five and six. However, the remainder of the work considers pregnancy loss and counselling from an anthropological perspective and makes use of library based research and interviews conducted by email with women who had overcome grief by a different means; namely by publicising their grief on the Internet with an exhibition of photographs and obituaries dedicated to their dead babies.

The hypothesis at the start of the study was that the performance of counselling is a specific procedure that brings about the resolution of grief following pregnancy loss for some individuals. Although this hypothesis is supported in the findings of the evaluation the meaning of the statement changes when viewed from an anthropological standpoint. While counselling is a procedure, like any other ritual performance that can bring about a change in consciousness of some participants, the findings suggest that it may not be the actual ritual of counselling that brings about the resolution of grief but the fact that respondents have had the opportunity to present a performance of any kind (Rosaldo 1993). This is evidenced by control respondents who took part in the study and also by respondents who were interviewed by email. These respondents did not have counselling

following a loss but were able to manage their grief, usually by a method that was performance related in some way.

The study also suggests that the reactions of humans to specific traumatic situations in life are not constant but change over time, according to the cultural narrative of their society and the historical period in which a trauma takes place. One argument put forward in this thesis is that as the attitudes of western society change toward pregnancy loss so too does the way in which individuals react to pregnancy loss. Throughout history the cultural narrative of every society is being constantly re-invented, although in some societies the changes are more dramatic and take place within differing time scales. Giddens (1991) maintains that the response to these changes by people living in a particular social order is as a reflex reaction against the cultural traditions and conditions of that society. Counselling too might be seen as a reaction to the present cultural narrative of the West where pregnancy loss is still regarded as a linguistically taboo subject. According to Mattingly (1988), counselling is just one of the many rituals of life that can aid participants to bring about a new personal narrative, which by way of reflex reaction might eventually transform the attitude of society at large toward what is at present a *recondite* event.

The social explanations of pregnancy loss are discussed in some depth throughout the text but medical causes of loss are conspicuous by their absence, since these are focused upon extensively in medical literature. Cases of elective abortion (abortion for any reason other than for foetal abnormality) or neonatal death are not considered.

Chapter one looks at pregnancy loss from an historical and cross-cultural perspective, and addresses issues such as separating rituals performed to guard against the polluting effect of pregnant woman and the cultural narratives which suggest that pregnancy loss is the result of ignoring taboos and restrictions placed upon the pregnant woman. Also explored are the notions of various cultures that describe pregnancy loss as a natural process.

Chapter two considers embodiment, the loss of self-identity and stigma often associated with a loss. The impact of technology, which has had a huge influence on the approach to childbirth today, and its effect on kinship ties of the mother to the unborn baby is

examined. Other issues addressed include the inconsistency in attitudes towards death in western society, emotional reactions to death, funeral rites, and the question of when life begins. Although the aforementioned subjects are diverse in their nature they all impinge upon or encompass pregnancy loss and have a bearing on this study.

The theme of the review changes in chapter three to investigate the use of counselling in post-modern times, its history, and its supposed therapeutic effect in the management of grief following pregnancy loss in the UK. Examples of British women and those from ethnic minority groups living in UK are presented to support the claims of counsellors who contend that counselling is effective in the resolution of grief. The literature review concludes with an examination of the connection between counselling, narrative theory, performance, and ritual. Also considered are the views of certain social scientists and medical professionals whom question the legitimacy of counselling as a therapy and who propose that counselling might even have a negative effect on patients.

The details of the research, which was carried out in 1999/2000 on behalf of the management of the Division of Women and Children at South Cleveland Hospital on Teesside, are recorded in chapter four. A clarification of the historical, social and medical background of South Cleveland Hospital and Teesside is followed by the methods section, which explains how data for the evaluation was collected. The ethical considerations adopted throughout the investigation are also outlined in this chapter along with a summary of the key findings.

Part of the original report that was presented to South Cleveland Hospital is included in chapters five and six. Here the discourse concentrates mainly on the findings of the evaluation of the counselling service and addresses the concern of the hospital management in relation to the need and effectiveness of the service. Chapter seven, while citing the narrative of respondents who took part in the study, also brings into play data taken from respondents interviewed by email and information gathered from library-based research. Pregnancy loss and the practise of counselling are considered in this chapter from an anthropological perspective with an examination of the changing face of society and emotion as well as the effect that these changes might have on embodiment issues for women. Also explored are the relationship of the client and the counsellor,

public performances of grief, and the theory of counselling as a ritual of post-modern times. The chapter ends with a synopsis of issues that would need to be addressed if an anthropology of counselling is to be researched in any subsequent study. Conclusions drawn from the study are presented in chapter eight. Detailed tables, charts and histograms of the results can be found in the appendices along with recommendations given by patients and professionals concerning their hopes and expectations for the counselling service at South Cleveland Hospital in the future.

Chapter one commences with a consideration of the changing attitudes toward failed pregnancy in preceding centuries, both in the West and across various cultures, which the writer believes is an indication that reaction to pregnancy loss at any given time in history is very much dependent on the cultural belief system of that society at that particular time. The discussion also supports the theory that if the cultural narrative of a society dictates that failed pregnancies are not caused by bodily malfunction, but are the result of supernatural intervention, then women seem better equipped, psychologically, to deal with failed pregnancy.

Chapter One

Beliefs and Superstitions Surrounding Pregnancy and Pregnancy Loss

1:1 Pregnancy Loss From a Historical and Cross-Cultural Perspective

Historically, issues of pregnancy and childbirth were surrounded by, and immersed in superstition (Donnison 1988:15). The performance of human reproduction was seen as a magical phenomenon, the outcome of which depended very much upon the relationship of the pregnant woman with beneficent forces or spirits that were thought to be responsible for a woman's bountiful condition. Childbirth has long been regarded as a female mystery universally associated with the moon, a symbol of fecundity and the night, but also of death and rebirth. Elaborate rituals were dedicated to the moon for fertility in marriage and safe delivery in childbirth and because of the strength of the moon's influence in pregnancy even the corpse of a stillborn baby was thought to possess healing powers. However, with the rise of Christianity and the doctrine of 'original sin' every child entering the world was categorized as impure until the sin was removed by baptism. A child who was not baptised before death was regarded as a powerful source of evil and remained a child of the devil (ibid).

During the 17th century in the UK pregnancy loss could be a risky business. If a pregnancy did not result in a live birth the unfortunate woman might be accused of infanticide unless she could prove that the loss of the baby had come about by natural causes, especially if she was unmarried or of low socio/economic status (Jackson 1996:199). In an attempt to ascertain whether or not a baby had been born alive both the woman and the products of her conception were subject to rigorous medical examination. In many communities, if a child was stillborn, the midwife was also accused of infanticide and of using the flesh of these un-baptised infants for satanic purposes, as in Shakespeare's *Macbeth* (Donnison 1988:17). Confessions of guilt were extracted under torture before the mother and the midwife were executed for witchcraft. It was thought that midwives, by the very nature of their work, had unlimited access to un-baptised infants and so intra-uterine baptism by syringe was introduced to thwart the so-called witches in their satanic practices (Needham 1959:232). To verify that foul play did not take place in the delivery room midwives urged each other “not to let any woman be

delivered in secret and always to have two or three honest women present and two or three lights ready (Donnison 1988)."

At that stage in history medical science was sufficiently advanced to establish whether or not a foetus was adequately developed to have survived birth but it was extremely difficult to tell if it had in fact been born alive. Eventually it was accepted that not all failed pregnancies were as a result of murderous mothers and midwives and to distinguish between live and stillbirths the 'hydrostatic lung test' was introduced in the early eighteenth century. The lungs of stillborn babies were put into water. If the lungs floated it was pronounced that the baby had been born alive. If the lungs sank the baby was deemed to have been stillborn (ibid:207). These tests were still being carried out in the nineteenth century and any woman giving birth in secret to an illegitimate child and claiming it to be stillborn was found guilty of murder. Although western women are no longer publicly accused of purposely ending unwanted pregnancies, the question of whether a loss came about by accident or design is still asked furtively by society. Subsequently women who experience pregnancy loss remain silent rather than risk veiled accusations of guilt.

1:2 Separating Rituals To Guard Against the Polluting Condition of Pregnant Woman

Historically in many cultures pregnancy and childbirth were seen as polluting conditions, not only to the woman but also to anyone who came into contact with her. A newly born child was also regarded as an unclean creature because of the defiled part of the body it had emerged from (Walker 1977). The *Mahabharata* stated, "Man is born out of lust, engendered by blood and semen, and emerges mixed with excrement and water." The Roman orator Pliny said, "it is humiliating to the pride of man to consider the pitiable origin of this most arrogant of creatures." And St Augustine wrote, "Inter faeces et urinam nascimur" [we are born between excrement and urine] (Walker 1977:26). The Cathars of the twelfth century also spoke of the profanity of newly born child.

"Conceived in base desires, born of brutish urges and animal postures, encased for nine months in the body of an unclean creature, and expelled from the womb in a cataract of blood, mucus and dead tissue (ibid.)."

The polluting condition of pregnant women is still prevalent in many societies today. The Zulu women of South Africa are considered both vulnerable and polluting when pregnant and move into a marginal state until after the baby is born (Callaway 1993:159). A woman’s highly polluting state when she gives birth is considered contagious and dangerous, not only to the virility of men but also to the baby. According to a study carried out among the Zulu (referred to in Callaway 1993:159), from a sample of 161 cases of infant mortality 36 percent were attributed to a woman’s vulnerability to pollution during gestation. For this very reason many ceremonies or rites of passage are attached to childbirth to ensure that pollution does not affect the rest of society. Often the first rite to be performed is the separation of the pregnant woman from society so that she will not be a source of contamination to others. Because she has been removed from her social role it also means that she can be re-integrated into society, cleansed of impurity, after the birth has taken place.

An example of this separation in pregnancy can be seen in the practices of the Toda community of India (van Gennep 1960:42). When a woman first becomes pregnant she is forbidden to enter the sacred places. In the fifth month of pregnancy a ceremony called ‘*village we leave*’ is performed and the woman is sent to live in a special hut where she is segregated from social life. While in the hut she invokes two deities, *Pirn* and *Piri* and burns her hand in two places, possibly as a sign to the rest of society that she has the protection of the deities. After drinking sacred milk she is allowed to return home until the seventh month of pregnancy when the ceremony of the ‘*bow and arrow*’ is performed to establish a social father for the unborn child (the Todas practice polyandry). The coming and going between the hut and the village and also the ceremonies continue until after the baby is born. The practices vary according to whether this is the woman’s first or a subsequent child and whether the father is deemed to be the father of any of her other children. After the child is born the mother, father and child are all tainted with an impurity called *ichchil*. Ceremonies are performed to protect all three against evil spirits and after being cleansed by the drinking of sacred milk they are reintegrated into ordinary life (ibid.).

In Western society what used to be a totally female activity has now been taken over by men. The business of childbirth is in the hands of obstetricians who have become ‘high

priests' in the contemporary birthing ritual (Callaway 1993:153). With the medicalisation of childbirth western women are still subject to rituals and ceremonies, as in other parts of the world, but the National Health Service usually perform these. Throughout the duration of pregnancy a woman is expected to visit the antenatal clinic, or should I say anti-natal clinic since some of the ritual practices carried out in modern childbirth seem to be extremely anti or hostile to natural birth (Davis-Floyd 1994). These might include a woman being taken away from her family, stripped of personal clothing and given a scanty white gown to wear that is open at the back which adds to the woman's vulnerability. Blood is drawn from her arm via a needle and she is asked to produce a sample of urine in a bottle. She is also given the obligatory folic acid tablets to be taken religiously on a daily basis throughout the pregnancy. And all of this takes place before she endures the embarrassing and often painful internal examination, usually performed by a male consultant.

When the woman emerges from the antenatal clinic after her first visit she is a fully-fledged expectant mother and as such society begins to treat her differently. She is excluded from any social activities that are considered too strenuous and is scolded for doing anything that might jeopardise the well being of her unborn child, thus emphasising that if the pregnancy is not fruitful it will be her own fault. As the pregnancy continues so do the ritual performances. The expectant mother continues to visit the antenatal clinic regularly throughout the pregnancy, urine sample in hand. If she has not adhered rigidly to the required ritual procedure she may be hospitalised and separated from society, sometimes for the entire duration of the pregnancy. The birth itself can be full of ritual practices as well, which once included shaving off the woman's genital hair and strapping her legs to posts to keep them apart. But now with recent technological advancements the ritual entails hooking the woman up to all manner of electrical contraptions, such as the foetal monitor and epidural, paraphernalia that severely limit her movement. She might even be induced to give birth at a time that is most convenient to medical staff. No small wonder that childbirth is referred to as confinement.

"These rituals dramatically show the birthing woman that she is not only separate from her baby and from her dysfunctional body-machine, but also dependent on the institution's more perfect machines to control the birth of her baby, society's product (Bieseke & Davis-Floyd in Laderman & Roseman, 1996: 294)".

Traditionally in the UK both mother and child were considered to be unclean until they had been ritually blessed by a ceremony called '*the churching of women*'. This ritual is performed by a priest and is designed to cleanse the mother and child of their sinful state (Van Gennep 1960:46). Women who were not ritually cleansed in this way were not welcome in the homes of friends or family. Van Gennep points out that during the Middle Ages this ceremony would acknowledge the woman's re-integration into her family, her sex group, and her society. Although this ceremony remained popular well into the 20th century it is no longer practised to any extent in the UK. Presumably the church would also ritually cleanse women who had miscarried or given birth to stillborn babies too, thereby finalising the pregnancy and reintegrating the woman back into society.

1:3 Unobserved Taboos and Restrictions Suggested as the Cause of Pregnancy Loss

Not only did pregnancy loss bring the moral conduct of women into question, it was also seen as a punishment for 'wrongdoing'. Cecil (1996:3) believes that a number of fairy tales identify the loss of a baby as castigation for bad actions. To illustrate this Cecil relates the story of *Rapunzel* in which a man is allowed to keep a lettuce he stole for his pregnant wife from a witch's garden in exchange for their unborn child. She also portrays the story of Tom Thumb, a child born at three months gestation to a barren woman who solicited the magic of Merlin to cure her of barrenness. Because Tom Thumb was born out of his mother's uncontrollable desire to have a child he would not be born at full term and although born alive would not reach maturity.

Cross-culturally there are several superstitions that suggest evil spirits accompany pregnant women and so they are urged to observe the cultural taboos of their society to avoid miscarriage (Waring 1989:181). Among the Dowayos, it is believed that if a bow is pointed at a pregnant woman she is liable to miscarry (Knight 1991:392). The Pocomchi of New Mexico say that during an eclipse pregnant females should stay in doors so that they don't see the moon in its struggle. Pregnancy loss is also attributed to noise (ibid.:502). According to an old German superstition a pregnant woman who looks at a dead body will give birth to a stillborn child. Women were encouraged to carry a sock belonging to their husband to avoid a premature birth. In other parts of Europe it is considered unlucky for pregnant women to spin, step over a grave or a cat, or to drink

from a cracked cup. In Victorian England women were urged to keep their mind on ethereal concerns by looking at beautiful paintings and listening to uplifting music, since it was believed that strong desires or impure thoughts would cause miscarriage or a malformed foetus. Thus when women miscarried or gave birth to a child with physical deformities it was naturally attributed to the woman’s weak or immoral character.

Finkelstein (1991:56) states that over the centuries explanations of human anomalies have also been attributed to several supernatural and mythical creatures including devils, centaurs, minotaurs, and satyrs and were a warning of what would result from unnatural human desires and acts. Some of these fantastic views have persisted throughout the centuries in one form or another.

“Associated with certain religious orthodoxies is the belief that those with physical deformities are the product of individuals who have sinned or transgressed against fundamental laws of God or nature (ibid.).”

According to a study carried out by Homans (1982:222) with 39 immigrant women from South Asia and 39 British women it was found that traditions prohibiting certain foods, and actions such as bending, stretching or lifting heavy objects were common to both Asian and British woman; the prohibitions were most often enforced by the mother of the pregnant woman or her mother-in-law. What is different between the two groups are the reasons for prohibition of certain foods. Dietary restrictions among British women relate more to foods that cause bodily discomfort in pregnancy, such as heartburn and indigestion, and these are mainly cheese sauce and fried foods. But blighted potatoes are believed to cause spina bifida in a foetus. The Asian woman, especially those whose Unani or Ayurvedic system of medicine distinguished between the heating and cooling effects of food, believed the consumption of certain foods would cause miscarriage. Similar to the British women they too abstained from eating fried foods and also ‘hot stuff’ such as curries, chillies and peppers. Even Coca Cola is forbidden because its high gas content might cause a baby that is not too secure in the womb to abort. Some of the British women said their doctor had advised them that smoking cigarettes, drinking alcohol, taking un-prescribed drugs and having violent sex could harm the baby. However, Homans (1982:235) points out that the doctor, while informing women of what

is appropriate behaviour for pregnant women, makes assumptions about the amount of control that British women have in determining sexual relations.

According to Shabazz, (2000), women from some ethnic minority groups living in Britain say that miscarriages are a "pay-back" for some thing evil that a woman has done or has within her. Pregnant women are told "don't walk this way you will miscarry, don't get upset you will miscarry, don't eat this you will loose your baby". Shabazz maintains that culturally some women have been conditioned to believe and accept that it is strictly their fault, and it was something the woman could have avoided. But one must not forget that the worth placed on a woman as an individual in some communities is measured by how many children she bears. Islamic women who have repetitive miscarriages are told it is their own '*evil fault*' that the pregnancy ended in miscarriage. Asian woman also believed that if the shadow of a barren woman falls on a pregnant woman that she might miscarry, "thus reinforcing beliefs about the anti-social powers of childless women"(ibid). But the notion that miscarriage is a "pay-back" for wrongdoing is still prevalent among some western women.

"The worst part for me is I had an abortion when I was younger and now I can't seem to have any kids. It's like a punishment or something and time is running out. I mean I will be too old soon and won't have the chance of having any. It's all very depressing." (counselled respondent)

"I felt that I was being justly punished for my crime – 'An eye for an eye'. My self-esteem and self-worth was so low at the time that I truly felt like I deserved this continuing pain and disappointment. (Interview by email Canada 2001)."

1:4 Miscarriage Described as a Natural Process

Nevertheless, in many cultures miscarriage is regarded as a natural biological or spiritual process for eliminating embryos not capable of surviving. In Bijnor, North India (Jeffery & Jeffery 1996:21) it is believed that when women miscarry no amount of medical assistance could have prevented the baby from 'falling' since the woman was either possessed by an evil spirit, (*asar, bhut, hawa or satao*) or cursed by the evil eye (*nazar*). Because women in some parts of India tend to have lengthy and complex maternity histories, from mid teens to menopause, a miscarriage is often not detected during the first trimester of pregnancy anyway. Women try to conceal pregnancy for as long as possible since being pregnant is considered shameful and pregnancy loss, like menstruation and

childbirth, entails defilement from dirty blood and is not spoken about openly. Pregnancy loss for the most part goes unnoticed in a society where high levels of fertility and infanticide are prevalent (ibid.).

The socially constructed traditions and belief systems of some societies, such as Jamaica, do not blame women for stillbirth or miscarriage because to them the loss of a child is clearly the work of an outside agency. During anthropological investigations into reproduction carried out by Sobo in 1988-89 it emerged that among Jamaicans several unorthodox ideas about conception and birth are common. A woman is not considered truly pregnant, a *belly woman*, until the quickening occurs, this is the time when the baby begins to move in the womb, or *baby bag*. Before that time a foetus is not considered human but thought of as a wayward clot of blood and mucus, which at the quickening turns into a baby. Anything that leaves the body via the vagina before the quickening is not considered as human remains. With the exception of detachment, when the baby is jolted from the *belly bag* by sudden physical movements or hard work, no other natural causes for pregnancy loss seem to exist (Sobo 1996:41). If a miscarriage happens after the quickening it becomes clear to the Jamaicans that it was not a real pregnancy after all but a *false belly* brought on by the *duppies* who are offended ancestral ghosts known to create unnatural babies. *Duppies* are also known to kidnap or kill babies as they are delivered and an *Obeah* or sorcerer is blamed for having set a *duppie* to trick or 'fix' a woman in order to bring her down (ibid:42.).

Explanations of pregnancy loss given by the Abelam of Papa New Guinea are also attributed to social and spiritual rather than physical causes. A failed pregnancy is thought to come about because of conflicts within the family or because spirits have been offended (Winkvist 1996:66). Although the *wala* spirits are needed for conception to take place if a woman breaks a taboo, such as singing loudly by the river, stepping on sacred stones or using a sharp knife, the *wala* will cause the woman to miscarry. However, the Abelam do not totally exonerate women from responsibility in pregnancy because they also believe that if a woman works hard throughout the pregnancy the baby will be strong and healthy '*pikinini bai kamap gutpela*' but if she stays at home and takes lots of rest the baby will be weak and skinny '*pikinini bai kamap bonating*'. According to Winkvist this ensures that women will always be available to fetch water, collect firewood and tend the

garden. Incidentally the only children who are considered strong enough to be accepted into Abalam society are those who are able to draw breath without assistance from an adult. If the child does not cry when it is born, even though it is moving and shows signs of life, the baby is left for dead. While this ensures that no children are kept alive with disabilities, demanding a higher investment in time and valuable resources from parents, it might be construed in western social terms as a form of infanticide.

The philosophy of the ‘external’ and ‘internal’ causes of pregnancy and pregnancy loss is reminiscent of Young’s (1986:141-142) discussion of aetiological and physiological explanations of disease. External causes of sickness might be ascribed to witchcraft or to disgruntled ancestral spirits who are punishing the victim for their lapse in customary duties while internal causes are attributed to the breakdown of the mechanics of the body and by the invasion of pathogens into the system. According to Young while most medical belief systems employ differing combinations of both systems, in general it is the structurally simple societies that adopt aetiological or external explanations of disease while more complex societies diagnose illness as being of physiological or internal cause.

Although in the West women are no longer overtly accused of purposely bringing about miscarriages, a remnant of this attitude from the past might remain with us today. Some women still feel they are being punished for their sins when they are not able to produce children, and society does nothing to alleviate these concerns. In many societies women are not blamed for failed pregnancy but are supported by the beliefs of their culture, which allows their social identity to remain in tact even if a pregnancy fails. Whereas in western societies women not only lack support from their cultural narrative but thoughts of failure are compounded by the fact that one’s effectiveness in society is measured by the orderly functioning of the body. Although the advent of modern technology may have improved the foetal and maternal mortality rate in childbirth it has done little to improve the self-image of women whose bodies, for one reason or another, fail to live up to the present medical model of ideal womanhood in a society where the perfect body rules supreme, as I will show in chapter two.

Chapter Two

Western Concepts of Body, Social Identity and Death

2:1 Embodiment, Self-Identity and Stigma in Pregnancy Loss

“Our understanding of ourselves and the world begins with our reliance on the orderly functioning of our bodies. This bodily knowledge informs what we do or say in the course of daily life. In addition, we carry our histories with us into the present through our bodies. The past is ‘sedimented’ in the body; that is, it is embodied (Becker 1997:12).”

Women who experience pregnancy loss are encouraged by society and the medical profession to believe that their body is in some way abnormal because of its failure to reproduce. According to Becker (1997:12) our embodied experience is what we see, what we feel, what we are, and what we know about our self and our surroundings and exactly what our embodied experience represents to us will depend very much upon our cultural narrative. Bodily experience is not only personal but also reflects shared social experiences of the culture in which the experience takes place, encompassing the past, present and anticipated future (Becker 1997). Valuable insights about cultural phenomena can be obtained by viewing the embodied experiences of people in social groups because in doing so we are privy to the place where people and social institutions interconnect (ibid.). Humes and Clark (2000) suggest that although as individuals we only experience a few of the infinite number of possible experiences, those we do encounter shape our identity, beliefs, values and worldviews. Our experiences enter the mind through the body and each new experience encountered adds to our cognitive categories, which are passed on to future generations through enculturation.

One reason that prompted the present concern with embodiment was Turners’ investigation into the ‘ideological’ and ‘physiological’ poles of the human entity (Laderman & Roseman 1996:4). However, a re-examination of the theoretical constructs that distinguish between mind and body, and person and society, was prerequisite when researchers such as Csordas (1994), began investigating health and illness in Society. Csordas argues against the Cartesian mind/body divide, suggesting instead that the public world and the private self are mediated through the body and that the body is constructed

because of cognitive experience in the world (Humes and Clark 2000:26). According to Laderman & Roseman (1996) feminist theory also provoked a shift in attention from ‘kinship’ to ‘gender’ to the ‘body’, evidencing that the *political* body is experienced in the *personal*. Burkitt (1999:90) says the body is at the heart of social and political struggles and gender politics is a central arena of conflict. The male body is seen as dominant and equated with the rational body politic while the female body is regarded as dangerous and irrational and is shut out of systems of power and control. Thus for women their destiny tends to be interwoven with their reproductive capacities.

Becker (1997) explains that when the body cannot perform its most essential acts the person becomes self-consciously aware of their body being a body. According to Diprose (1994) when women experience a failed pregnancy the bodily identity that has developed as a consequence of the sex-gender belief system of the woman’s social and historical background is lost. Everything she believed about herself, her body, and her valued place in society can potentially be shattered.

“I wanted to keep trying - I felt that if I got pregnant enough times one of them was sure to work out. I felt that I was at war with my own body and I didn’t want my body to win. My self-esteem was destroyed by the fact that I couldn’t seem to perform what I felt was a very basic biological function - bearing children. If I couldn’t do that - was I capable of doing anything else that other women seemed to take for granted? (Interview by email Canada 2001).”

In Thapan’s (1997) view issues concerning health, sexuality and productivity in Western society divide the healthy from the unhealthy in terms of what kind of bodies are deemed useful to our social and economic system. Foucault (1980) advocates that medical science has played a central role in postulating these ideas about ‘proper’ and ‘improper’ and ‘normal’ and ‘perverse’ bodies. As such, women who fail to meet the ideal medical model of womanhood, or do not prove effective in their socially designated role as child bearer, can become estranged from their previously embodied identity, both socially and sexually. But why do some women accept the theory put forward by medical science and society that a body that does not conform to the accepted cultural standard is inadequate in social terms? Foucault suggests it is because people are subordinate to an authority that has the power to dictate sexual identity. “The agency of domination does not reside in the one who speaks [the patient] (for it is he who is constrained), but in the one who

listens and says nothing [the clinician].... (ibid:62)". Although both men and women are under the domination of medical authority it is the male ownership of female sexuality, since the majority of physicians who treat female patients are male, which has added to the disempowerment of women (Laderman & Roseman 1996:294).

According to Douglas (1992:231) it has long been recognised by anthropologists that modern industrial society is hard upon the self-image of any person who fails to carry out his or her socially designated role and responsibilities. Douglas believes the reason why some people fail to measure up to what is expected of them by society is because "the burden of responsibility is often unfair" and "culture is so organised that incompetence and weakness cannot be compensated for (ibid)." In the 'enterprise culture' the rewards go to those who successfully fulfil their social duty while the punishment for failure is severe. Failure can lead to social exclusion even though the person excluded is not aware of this at the time. Exclusion can be a 'silent process' and even other people might not notice what is happening until some time after the event. "The enterprise culture just waves a wand and its rejects become invisible (ibid)." However, the rejects do not always become totally invisible. Women who suffer pregnancy loss are often socially excluded but are also stigmatised by society at the same time for failure to reproduce.

Kleinman, (1988:159) discusses the social significance of stigma and the effect it has on the lives of those so labelled. Although in the past stigma was something that could be visibly seen, such as a mark or disability, more recently it has come to refer to the disgrace or shame of a person. To be stigmatised is "deeply discrediting leading to spoiled identity and feelings of being inferior, degraded, deviant and shamefully different (ibid.)." Goffman (1963:15) says that we construct a stigma theory to explain the inferiority and account for the danger that a person who is stigmatised represents to society. When a person becomes stigmatised they take on an apparent change of personality. Evidence of this comes from experiments carried out with able-bodied individuals who temporarily assume the defects of the physically impaired and spontaneously display the reaction of those who have that defect permanently. Sometimes, if it is possible, the stigmatised person will make an attempt to correct his or her failing. For example a person who is physically deformed could have plastic surgery. If the failing is corrected the personality is likely to undergo a change to reflect the new

body image (ibid:157). But the stigma associated with failure to reproduce cannot be corrected unless the woman has a fruitful pregnancy at some time in the future, or her beliefs about her body and her culture can be changed by another means.

2:2 The Impact of Technology on the Approach to Childbirth

The Miscarriage Association say that the loss of a baby at any stage of gestation or for any reason can be a devastating occurrence that can perhaps only be truly understood by those who experience it themselves. A confirmation of pregnancy changes the feelings and plans of the family unit, bringing with it a whole range of expectations, hopes, fear, and dreams (Stewart & Dent 1994). With the aid of modern technology, in the form of pregnancy testing kits, prenatal investigations and ultra sound scans (USS), parents are aware of the developing embryo at a much earlier stage of gestation than in the past. Of course these technological advances undeniably contribute to the positive outcome of most pregnancies, both from the medics’ and the parents’ point of view. But for some parents knowing about a pregnancy at an earlier stage of gestation serves to reinforce expectations of a positive outcome to the pregnancy, especially after seeing a living, moving foetus on screen during the USS. However, Weir (1998:78) points out that personal use of foetal imagery has changed the previous meaning of ‘baby’. Before the technological improvements in obstetrics the term ‘expecting a baby’ meant a mother was awaiting the arrival of someone with whom the familial bond had not yet been formed, since the only evidence of the baby’s existence was the swelling and movement in her tummy. But when a mother has tangible proof of a baby’s existence, with the aid of foetal imagery, the ties of kinship are formed long before the birth (ibid). After this reinforcement of expectations parents are likely to experience a greater sense of confusion if pregnancies are not fruitful, especially when parents had assumed the wonders of modern medicine would guarantee their baby’s safe arrival (Kohner & Henley 1991).

2:3 When Does Life Begin?

Issues relating to when life begins and at what stage of gestation a foetus is accepted by society as being a viable human being have long been contentious concerns. Many people suggest that life begins when the soul enters the embryo at the moment of conception, while others maintain it is not until a baby takes its first breath. In some cultures, such as the Ainu, there is a liminal period after birth that lasts for twelve days

during which time the 'soul' is believed to enter the body and the child becomes a complete and autonomous individual. Some transitional periods can last from two to forty days after birth, as with the Arunta, Kaitish, and Warramunga of central Australia. This time is needed for the separation of the newborn child from the world of the dead and its incorporation into the society of the living (van Gennep 1960:53). If a baby dies within this liminal period it would be deemed the baby was never alive.

In the West many women believe their baby is 'alive' in the womb throughout the pregnancy and so it is difficult to accept that the foetus they have lost, at whatever stage of gestation, had no social or legal recognition in society. However, this appears to have been the case until recently but now bereaved mothers are attempting to draw public attention to the legal status of the nonviable foetus and the plight of the parents.

"It is now time to take stock and listen to the silent grief of mothers who do not dare to rock the boat by a seemingly silly request that society should view her pre-viable foetus as her own special baby (Lancet, editorial, 10th Dec. 1988)."

In the UK the legal age of viability of a foetus is twenty-eight weeks of gestation, although it is generally accepted among the medical profession to be twenty-four weeks. The legal age of viability was set in 1929 by the Infant Life Preservation Act but at that time very few babies born at earlier stages of gestation survived anyway. Today, many pre-twenty-eight week babies, and even twenty-four week babies, have a very good chance of survival with the aid of modern technology but since the Act still remains in force they are classed as nonviable in legal terms. Of course this is of no consequence to babies who survive, because the fact that they are alive gives them legal status. It is those babies who do not survive birth at early stages of gestation, and their parents, who are affected most by this archaic decree.

According to SANDS, (Stillbirth and Neonatal Death Society), when a baby of over twenty-eight weeks of gestation does not survive birth it is a requirement of law that the baby be registered and given a burial or cremation. Also, parental consent is needed before a post mortem examination can be carried out. However, there is no such legal requirement for pre-twenty-eight week babies even though they have a special status in the minds of their parents. After pressure from parents who look upon the products of

pregnancy as more than just a commodity for medical research this lack of social recognition for the nonviable foetus was addressed in the Polkinghorne Report in 1989.¹ The report recommends that although there are no legal requirements concerning the disposal of foetal remains, parents' wishes should be adhered to and provision should be made for respectful cremation or burial. In as much as society regards a foetus of less than twenty-eight weeks of gestation as not human, in social terms, this causes much concern to women who have seen their baby on the ultra sound scan. In many instances a woman has already welcomed the baby into the family unit, and if they know the sex, have named the baby.

The true impact of this situation has recently come to light with the organ removal scandal at Alder Hey Royal Children's Hospital, and other hospitals where it was reported that tissue and organs from the corpses of babies and foetuses were routinely removed for use in medical research, supposedly with the consent of parents. Boseley & Ward (2001) suggest that thymus glands taken from babies at these hospitals were sold to a French pharmaceutical company for use in the manufacture of a drug for aplastic anaemia. The thymus gland, a small piece of lymphatic tissue, is crucial to the health of a newborn baby since it plays a critical role in setting up the immune system to help fight off infection and so it is also of value in the prevention of acute rejection in transplantations. But parents deny they gave their consent for organs to be removed and feel they were deliberately kept in the dark about the eventual fate of the foetus and its organs. According to the health secretary, this has undermined patients' trust in the medical profession, which he says is so essential for the doctor and patient relationship. He also criticises the National Health Service for not being candid with patients.

"The days have gone where the NHS could act as a secret society. It cannot operate behind closed doors. It cannot keep patients in the dark. It has to take patients into its confidence. It has to actively earn the trust of patients in life and it has to actively seek the consent of relatives in death (Alan Milburn The Health Secretary in The Guardian Jan 30th 2001)."

But to the medical establishment foetuses under the gestation of twenty-eight weeks are not classed as relatives of the bereaved parents and even though the Polkinghorne Code of

¹ Review of the Guidance on the Research Use of Foetuses and Foetal Material HMSO 1989. The status of this report is made evident in the Department of Health Circular HC(89)23, which requests implementation of the Polkinghorne Code of Practice (in SANDS information booklet).

Practice recommends that foetuses should be treated with dignity this was not the case at Alder Hey or at many other institutions.

2:4 The Absence and Presence of Death in Western Society

Perhaps it is difficult for industrial nations to determine the beginning of life because the contrary to life, death, presents such a problem in society. The result being that there are several paradoxes in the management of death (Clark 1993:ix). Mander (1994) states that our attitude to loss through death tends to be similar to the Victorian attitude to sex – the ultimate unmentionable. (Also discussed by Arnason 1998:66) But Mellor (1993:11) argues that death is not unmentionable in western modernity although he agrees it remains hidden in the sense that it is usually sequestered from public space. To Mellor the subject of death poses a contradiction, being absent and present at the same time. While clinicians and scholars describe death as a taboo subject the increasing amount of literature on the subject suggests that this is not so anymore.

However, Hockey (1990:27) maintains that death is rarely confronted on a person level unless one is directly challenged by the death of a loved one. Even then it is kept at a distance, which is apparent by the increased use of funeral homes that serve to relieve the bereaved from having to deal with the disposal of the corpse. Death instils confusion and fear in many people and although it is slowly becoming less of a taboo to talk about it openly, death is an intangible process wrapped in a variety of metaphors and conceptual constructs (ibid). Yet interest in death and its relationship to life has raised much controversy and curiosity in every culture throughout history. Death is often a prime consideration of myth and religion and ironically death is the measure of life itself, since it is the death rate of a society that is used as a yardstick to appraise the success or failure of that society. But ostensibly, according to La Rochefoucauld (1678:in Hockey 1990:82), death, like the sun, “can not be looked at with a steady eye”.

Death is the ultimate fact of life in every society but many cultures acknowledge the presence of death in their cultural narrative instead of pretending that it does not exist. Mary Douglas (1966:176) explains that to the Nyakyusa, who are highly pollution conscious, death is seen as a great source of pollution. All bodily rejects, such as seminal fluids, menstrual blood, childbirth, faeces and corpses are regarded as very dangerous.

The Nyakyusa observe special rituals to separate the living from the filth of death, since contact with the dead is thought to bring about madness. In our own culture the imagery of death is described by Hockey (1990:27), as 'dehumanising' and everything possible is done to ignore or deny that death exists. Even religious orders assert the importance of the 'after life' and the significance of the immortal soul, in preference to focusing on the decaying mortal body. According to Seale (1998) death sits on the divide between nature, culture and dying and "the sense of loss that death engenders are episodes where the divide between nature and culture is seen in starkly clear terms (idid:11)." Human social life must be understood in the context of embodiment and the recognition that the body is finite. Seale suggests that our reaction to death is because it reminds us of our own mortality.

"We invest ourselves in the other people who we love, so that their loss is experienced as a loss of the self. When the people who we love die, then, a basic ambivalence emerges between the triumph of personal survival and grief at the loss of the self that is in the other person (Seale 1998:55)."

With pregnancy loss death is experienced as a loss of the self to a greater extent because the foetus had been part of the woman's own body. Death becomes even more perplexing when life and death are fused together (Mander 1994), involving neither the celebration of new life coming into existence nor the death of someone who has held a recognised place in society. As such, the casualties of failed pregnancy encounter difficulty in coping with a situation that is not only incomprehensible to them but also one that society, as a whole, tends to ignore.

"We are all brought up to believe that there is a divine providence in the laws of the universe. Things are meant to be as they are meant to be. The law of nature dictates that the strong will survive and the weak will die. You will not outlive your children; this is not the way of the universe. When you experience the death of your child nothing makes sense any more. Everything that you have ever been taught to believe in no longer applies. You are incapable of believing that what goes up will come down, that apples will fall off trees and that winter will, if history repeats itself, one day become spring. You have no idea what normal is anymore. You yearn for the world that you once knew. You want desperately to believe in the laws that you once trusted but suddenly nothing makes any sense anymore and you find yourself awash in a sea with no direction, no current and no paddles. This is probably the singular most frightening aspect of grief that the bereaved have to deal with (Interview by email Canada 2001)."

2:5 Emotional Reactions to Death

Mander (1994) suggests that the inevitable confusion or bewilderment that accompanies pregnancy loss is because new life and death are fused together. The simultaneous occurrence of these two events calls our entire perception of the world into question and contests the myth that life and death should be separated by the traditionally expected three score years and ten (ibid.). Although coming to terms with any death is difficult, Mander proposes that if the deceased has lived for some time, death is easier to accept because there is evidence of that person’s existence in the form of memories and how they might have affected our life. But to experience the death of one who has never lived stands reality on its head since we mourn a life with no memories attached to it. Kluger-Bell (1999) refers to pregnancy loss as the ‘*broken promise*’ believing that the idea of death before birth is almost too cruel to imagine and an offence against our belief in the cycle of life.

Emerick (2000:34) believes that death rouses many emotions, including fear of death itself and disgust at the decaying corpse. The tangibility of the “revolting, rotting mess” of the corpse reminds society that God, in the guise of ‘medical science’, has failed to “fix the mortality of the human body”, which also reflects society’s moral failure to correct the situation (ibid:43). This sense of failure may be even more pronounced when the corpse is that of a dead baby and since the baby has never lived parents cannot grieve the past life of the baby so must instead grieve for the lost future that they would have shared together as a family (Kohner & Henley 1991). If parents learn their baby has died before the miscarriage or delivery takes place they may experience anticipatory grief which begins while the baby is still in the womb. When the pregnancy is finally over and all remnants of hope have gone there is a confusing mixture of sadness and relief until the reality of the loss sinks in, at which point they can begin to mourn more fully (ibid.).

Stewart & Dent (1994) suggest that in the West there is a difference between grieving, which focuses on the person’s emotional state, and mourning, which involves a more socially orientated manifestation. Over the last 40 years a grieving process has been identified that designates different thoughts and feelings to stages of the grieving process that usually follow a certain pattern:

'Head-Hunting' (or Grief Management) on Teesside

- a phase of numbing that lasts from a few hours to a week and may be interrupted by outbursts of extremely intense distress and/or anger;
- a phase of yearning and searching for the lost figure, lasting some months and sometimes for years;
- a phase of disorganisation and despair;
- a phase of greater or lesser degree of reorganisation.

Whereas the four tasks of mourning, described by Stewart & Dent, differ from the later:

- accepting the reality of the loss;
- experiencing the pain of grief;
- adjusting to an environment in which the deceased is missing;
- withdrawing emotional energy and reinvesting in another relationship.
- (Stewart & Dent 1994:10).

In van Gennep's (1960:147) opinion, the mourning period is a time when the living mourners and the deceased constitute a special group, situated between the world of the living and world of the dead. The mourning requirements of a society are based on degrees of kinship and how soon the mourner leaves the group will depend upon the closeness of the relationship with the dead person. However, with pregnancy loss, society does not recognise the kinship ties of the deceased although bereaved parents still go through the same anguish.

Nevertheless, emotions that are aroused by death in the West may not be expressed in quite the same way by other cultures, since emotions differ according to cultural understandings, linguistics, and perceptions of mental health (Wellenkamp (1995:171). An extreme case in point is the Ilongot headhunters of the Philippines who describe a whole gamut of emotions experienced in bereavement by the word *liget* that includes anger and grief. In fact bereavement instils such deep *liget* in the Ilongot that head-hunting is the only natural form of release for them. Rosaldo (1984:1), while speaking of the Ilongots' response to death, said that rage, born of grief, impels them to kill their fellow human beings. The act of severing and tossing away the victim's head enables an Ilongot to symbolically vent and throw away the anger that is felt in bereavement.

This scenario, where anger and sadness are referred to by the same expression, is also prevalent among the Ifalukian with the word '*song*'. *Song* is used to describe a situation when a person cries, pouts, or when he or she feels angry. Similarly many societies make

no distinction between shame, guilt and embarrassment, including the Ilongot who use the word '*betang*' to cover all of these emotions. According to Russell (1991) studies carried out by Marsella in 1981 conclude that unlike in the English language there is no word for depression, anxiety or remorse in many non-western societies. Russell, (1991:430) maintains that although emotion itself is experienced universally the words used to describe emotion and the events surrounding its manifestation vary with culture. Differences are observed in the "frequency of, the causes of, the expression of, the importance of, attitudes toward, beliefs about, and the regulation of emotion" in different societies (ibid).

Lutz and White, (1986:417) say the concepts of emotion emerge as a language of the self in a moral order, revealing intentions, actions, and social relations. Emotion can also be defined as being about economic and social structures and the status of the individual performers of emotion. "Lower class status sometimes is seen as entailing either less emotionality, defined as personal subjectivity, or more emotionality defined as chaotic affect rather than refined sentimentality (ibid.)." In Western culture society calls for the repression of some emotions, such as anger in women and fear or sentimentality in men (Lutz 1988). Since society dictates that certain emotions should be displayed in particular situations and by particular genders it is apparent that emotions are a way of subjugating the masses and are under the jurisdiction of one's respective culture? Perhaps this is better reflected in the words of Foucault, who said that emotion is "the place in which the most minute and local social practices are linked up with large scale organisation of power (Lutz 1988)."

2:6 Funeral Rites and Rituals

Hindmarsh (1993) says that given the enduring nature of parental grief, fraught by feelings of failure and guilt, it is important that parents have a funeral for the child so that they know in their own mind they have 'done their best'. The funeral ritual is also helpful to make the loss real, not only personally for the parents but socially as well since it gives the opportunity of saying goodbye. Theoretically, funeral or mortuary rites are usually carried out to mark the removal of the deceased person from society and to re-establish stability in the social order. Thus it is a rite of passage for the deceased, the family and society. But since a dead baby held no recognised position in society, this ritual in social

terms is meaningless; apart from the emotional relief it affords parents. Arnason (1998) gives the example of the Malayo-Polynesian speaking people of Indonesia who believe mortuary rites are only for certain people in society. Children who have not been initiated are not considered a part of society and are therefore buried quickly and quietly since society has nothing to recoup from their passing (Arnason 1998:10). However, Arnason (1998:65) discusses the greater freedom that mourners now have to express their grief in the West and he asserts that it is not only the individuality of the deceased that is important but also the individuality of the bereaved in the funeral ritual. Arnason refers here to the 'do it yourself funerals' where the bereaved themselves choose the method of disposal of the deceased's remains, which does not necessarily have to be in a cemetery or crematorium. One can choose to bury dead relatives in the back garden if the necessary documentation is obtained.

This is a far cry from the pomp and circumstance of funerals held in the Victorian era, described by Littlewood (1993:77) as a 'golden age' for grief. These were very elaborate affairs that began by the laying out of the dead person in the front parlour of their home, hence the term funeral parlour. The funeral itself was a grand affair with no expense spared, depending on the financial status of the family. The nearest relatives would openly display to society that they are in mourning by wearing black for several months after the funeral. Eventually the family would slowly return to everyday life without feelings of guilt because they had carried out their social duty. Littlewood says that since the First World War and the decline in the death rate due to improvements in public health, the periods of mourning have lessened but some people still feel the need to make social reparation. Some individuals will work to help others who find themselves in a similar plight by raising funds for research or campaigning to change the ways in which bereavement is dealt with. Littlewood (1993:80) points out that membership of self-help groups such as the Stillbirth and Neonatal Death Society (SANDS) and the National Association of Widows (NAW) consist entirely of people who have experienced a similar type of bereavement. The feelings of *communitas* override any considerations of social hierarchy and the bereaved feel they are showing the extent of their grief to society by giving their time to help others.

However, not every bereaved person feels they are capable of offering support to others who are in a similar situation to themselves, at least not until they have resolved their own embodied experience of loss and grief to some extent. Whereas in the past grieving parents might have found solace in religion and the rituals provided by the church, as well as the family unit, these structures no longer have the same influence in today’s society. In order to come to terms with issues that might arise following pregnancy loss, such as loss of self-identity, sexuality and concerns about life and death, some bereaved parents still need the intervention of someone not directly involved in the situation. In recent years we have seen a blossoming of the ‘counselling culture’, which is estimated by some (Giddens 1991; Charlton 1998) to have taken the place of the more traditional forms of comfort. However, although counselling is gaining in popularity throughout the UK, counselling and often counsellors themselves are the subjects of much controversy because of the obscurity that surrounds the concepts of what counselling is and what counsellors do exactly. These issues are discussed in chapter three.

Chapter Three

Theoretical Models of Counselling and Links to Other Healing Scenarios

3:1 Counselling in Post-modern Times

According to Heelas (1996) the practices, beliefs and values of modern day counselling exemplify deep-seated cultural trajectories and are a response to the cultural uncertainty of our time. However, because counselling is so multifaceted, having more than 400 different approaches and referring as it does to many complex activities or situations, it is extremely difficult to obtain an accurate picture of its essence (Davis & Fallowfield 1994:23). This is not so surprising when neither the British Association for Counselling (BAC) nor the American Counselling Association (ACA) give an official definition of the word, although the BAC's Code of Ethics and Practice (revised in September 1993) does outline the aims and objectives of counselling in the following statement:

"The overall aim of counselling is to provide an opportunity for the client to work towards living in a more satisfying and resourceful way... Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis', developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others. The counsellor's role is to facilitate the client's work in ways which respect the client's values, personal resources, and capacity for self-determination (Howard 1996:24)."

Murgatroyd (1996) gives several other methods of approach that can be adopted in counselling; 'prescriptive', giving advice; 'informative', interpreting or giving instruction; 'confronting', giving direct feedback; 'cathartic', encouraging emotional discharge; 'catalytic', enabling self-direction; 'supportive', being approving. These six strategies are often grouped into two distinct styles of helping. The prescriptive or directive style of counselling, where the counsellor guides the client toward an appropriate action, and the facilitative or developmental style, when the client is helped to discharge his or her emotions and to reach their own realisation of appropriate action (ibid.). Doctors might counsel in the directive style, offering advice to patients to help them come to a decision about a plan of health care. Marriage guidance or bereavement counsellors would be more likely to adopt the facilitative style of counselling; helping

clients arrive at their own understanding of the circumstances and to find ways of resolving them. However, both styles can be effective and depending upon the situation counsellors might adopt both directive and facilitative methods of counselling (ibid.).

Arnason (1998:128), in his study of bereavement counselling, states that a death of any kind can leave the bereaved persons in a state of shock, feeling confused and vulnerable, and that counselling is reputed to lessen these ill effects. Worden (1989), remarking on the subjective efficacy of grief counselling, says that counselled patients following therapy make comments such as "the pain which has been tearing me to pieces, is now gone". They also speak of increased self-esteem and less feelings of guilt. Many patients report behavioural changes after counselling and find they are able to socialise more and form new relationships. Other counselled patients have noticed the passing of physical symptoms such as aches, pains, and lethargy that originated at the time of their loss. In many contexts bereavement counselling is seen as an activity where counsellors guide clients through the grieving process to ensure they do not get 'stuck' in any one phase. Bereavement counselling provides a means for expressing grief, working on the tasks of mourning, and dealing with suppressed anger and despair.

In spite of Worden's enthusiastic appraisal of the benefits of counselling, Kohner & Henley (1991) argue that although counselling can in some circumstances provide people with the chance to talk about and understand their feelings it is not a magic formula. According to Hindmarsh (1993) with bereavement counselling, even though referrer and client hope the counsellor will say or do something miraculous to 'make things better' this is not really the aim of counselling because the focus of the work is always with the client who sets the pace and the agenda of the proceedings. It is difficult to measure the benefits of counselling, as it is with any healer/patient therapy, because most accounts of treatment usually concentrate on successful cases (Budd & Shama 1994:16). Budd and Sharma suggest that only practitioners who encourage patients to talk about the negative aspects of treatment are likely to find out if patients' are really benefiting, and since most patients are unlikely to complain, this rarely happens. It is also difficult to conduct research with people who are no longer having therapy with the original bereavement counsellor because they may have subsequently seen different counsellors or had other therapies. Of course the simplest explanation for people coming to terms with grief could

be the length of time that has passed since the loss took place, given that traditionally 'time' is said to be 'greatest healer'.

Nevertheless, there is still much confusion and uncertainty about the exact definition of counselling even though at any given moment there are innumerable people throughout the world engaged in its application. Feltham (1995) maintains that to the uninitiated '*counselling*' still carries its traditional meaning as defined in the dictionary; as giving advice or counsel to those who are experiencing difficulties in life. An intimate conversation with confidantes, in the belief that a 'problem shared is a problem halved' or that 'getting it off one's chest' will alleviate a dilemma, might also be construed as counselling. However, Feltham points out that over the past decade counselling has taken on new characteristics and is now recognised as a respectable social service offered by professional counsellors who are highly trained in its practice.

To be fair it is not only the practice of counselling that is described as vague and obscure in late modern times, the whole of Western society is accused of being fraught with ambiguities and contradiction (Habermas 1987:5). According to Berger (1973) in this most recent interval in history, imagination is thought to have taken precedent over logical reasoning resulting in an upsurge of many new ideologies and therapies believed to be designed to counterbalance the growing antipathy toward worldly affairs.

Giddens (1991) believes that the current globalising tendencies of modern institutions are having a profound and transforming effect upon the day-to-day social life of individuals. In his opinion the intangibility of 'high modernity' might be the anticipated result of a society that has become too preoccupied with rationalism in the Industrial Era. He discusses the transformation of self-identity which are expected to occur with the new found ideology of 'high-modernity' but expresses grave misgivings about transformations which are not based on tried and tested traditions. Giddens explains that while traditional cultural transitions, or changes of identity, have in the past been accompanied by psychic recognition in the form of rites of passage, "in the settings of high-modernity the altered self has to be explored and constructed as part of a reflexive process of connecting personal and social change (Giddens 1991:32)." Giddens refers to the era of 'high-modernity' as the 'risk society' since individuals lack psychological support and a sense of

security provided by the more traditional settings. He feels the risks introduced by present day society are the back-lash of an out of control society where people are applying therapy and counselling as the equivalent to a secular version of the confessional and as a form of support, previously provided by traditional ideologies (Giddens 1991:29). Therefore Giddens asks, is therapy only a means for adjusting dissatisfied individuals to a flawed social environment? Or are these things narrow substitutes for the deeper range of spiritual involvement experienced in pre-modern settings?

3:2 The Antecedents of Counselling

According to Hodgkinson (1992) counselling and psychotherapeutic theory, in the form of psychoanalysis, psychotherapy, and transpersonal therapy, have been around since the early 1900s. To understand and unscramble the complex lineage of psychiatric thought behind modern forms of counselling in this century, Grossinger (1991) suggests we go back to the father of psychoanalytical thought, Freud. It is his work on the nature of the mind, carried out at the end of the nineteenth century, which has saturated our culture and still influences our institutions today. Central to Freudian analysis is the doctrine that many conflicts and problems we encounter in life are the result of unconscious motives and feelings that resist being brought into consciousness. Psychodynamic counselling is thought to help clients understand these unconscious motives, bringing them into conscious awareness where they can undergo analysis (Hodgkinson 1992). Freudian analysis came to be known as the 'talking cure'. Although many people still refer to counselling in this way it is now considered to be not so much a cure as it is a healing process which takes place through talking about thoughts and feelings to a listener who can provide a special quality response (ibid.). Nelson-Jones (1995), a founder member of BAC, suggests the term counselling is related to, or overlaps with, several fields of psychotherapy and psychology but in the past attempts to differentiate between counselling and psychotherapy have not been entirely successful. However, according to Nelson-Jones, psychotherapy focuses on some sort of personality change while counselling is orientated toward helping people use existing resources to cope better with life events.

Perhaps the person who has had the greatest impact on counselling in this century is Carl Rogers. Rogers moved away from the 'external frame of reference' of the psychodynamic

and behavioural schools and initiated the central concept theory where the views of the client are the focus of both theory and therapy (Davis and Fallowfield 1994). It was in 1940 that Rogers made his first attempt at crystallizing in written form some of the principles and techniques of a newer approach to therapy, then known as 'nondirective counselling' and first published in a paper entitled '*Newer Concepts of Psychotherapy*'. Rogers rejoiced at his privilege of being, as he termed it, a midwife to a new personality; "as I stand by with awe at the emergence of a self, a person, as I see a birth process in which I have had an important and facilitating part (Rogers 1951)". Counsellors who are involved in the person-centred counselling devised by Rogers use such terms as 'active listening' and 'rewarding listening' which some believe is sufficient to trigger constructive changes in clients. Nevertheless, Rogers himself is the first to admit that this therapy will not help every psychological condition but says "a psychological climate which offers an individual the opportunity to gain a deeper understanding of self, will be invaluable in helping that person toward a re-organization of the self (ibid.)."

3:3 Counselling and Ethnic Minorities

Though the aftermath of pregnancy loss can be devastating for Asian woman, according to a study carried out by McAvoy & Donaldson (1990) with the Asian population of Leicestershire, they rarely take up an offer of counselling, even following a termination. Rawson (1999) maintains this is because the practice of counselling is set within a historically and culturally narrow attitude. Evolving as it has from mostly psychodynamic, cognitive behavioural and humanistic traditions, it is at odds with the increasingly multicultural society in Britain today. Rawson states that many psychological issues affect people who live in cultures predominantly different from their own. These issues could include reactions to racial oppression, the influence of the majority culture or their own culture, and individual and family experiences and endowments. Kitano & Maki (1996) say that anyone wishing to interact with people from differing cultural backgrounds must first understand their religious beliefs, family dynamics, and the psychological constitution of the person. Although counsellors may have empathy with ethnic minority clients, there may be communication difficulties between the client and the counsellor. However, communication is not only about speaking the same language, it is also about body language and depending upon a client's

experience of white people and the therapist's experience of black people, the communication between them might be confusing or even hostile.

Corey (1996) states that women who originate from cultures that are patriarchal might not see themselves as having any personal identity, therefore counselling could be in direct conflict with a woman's position within her social framework, especially if she has experienced an oppressive environment. An example of this might be the social and psychological consequences of living in an extended family network such as that of Asian Indian society that is family orientated and community based (Rawson 1999). The individual ego of an Indian, male or female, is subject to collective solidarity, so much so that they often use the pronoun 'we' (*hum* in Hindi) when referring to themselves (ibid.). When a problem arises, be it medical, financial or whatever, it affects the whole family and since western style counselling and therapy are centred on the 'self', it could present some Asians with a dilemma (ibid.). For second generation immigrants the difficulties can be more pronounced as they try to straddle the chasm between their parent's culture and the one into which they were born.

There are also religious issues to take into consideration. Women from ethnic minorities may not accept an offer of counselling following bereavement because their religious belief system gives them a degree of comfort or explanation for the loss. It is very important that those taking care of people from different cultural backgrounds show respect for their religious practices but since some religions make no formal provision around miscarriage and stillbirth there may be no clear cut rulings as to what should be done (SANDS). Hindmarsh (1993) points out that with many religions the tradition is to hold the burial ritual less than 24 hours after the death, which would be extremely upsetting for British parents. Also taking mementos from a dead baby, such as a lock of hair or footprint, that many westerners find comforting, would not be acceptable to Hindus or Muslims who believe the body should not be touched after death. Because of differences in cultural practice medical personnel should be equipped with some basic understanding of what is acceptable to women and their families and should be given formal training in this area (SANDS).

It is evident that not everyone has a need to be counselled or indeed that counselling has a beneficial effect on every person that receives counselling. Therefore the question arises, what is it that counselling does for some people that can help them overcome grief and move on in life? According to some writers, (Mattingly 1998; Becker 1997) it could be the invention of a new narrative created during the counselling sessions, or the chance to act out their feelings of grief publicly, that helps certain people to regain control of their lives following a traumatic event.

3:4 Narrative Theory, Ritual Performance & Counselling

Mattingly (1998:81) writes about the importance of narrative in counselling but says the telling of a narrative might differ depending on the relationship formed between different therapists with the same client, or between the same therapist with the same client on different occasions. This is because relationships between all individuals change on a daily basis, with the mood of one person having a subtle influence on the other, thereby affecting the narrative on a particular day.

"Stories or narrative are somehow jointly produced, and not by the patient alone, as it might appear on first glance; but between patient and therapist through a subtle and elusive interaction of the two (Mattingly 1998:43)."

Becker (1997:25) maintains that narratives are empowering and can be reshaped in the telling of them or changed with subsequent experiences. McAdams (1993:240) refers to the 'generativity' of narrative as the constructing of personal myths that help an adult formulate a script of what he or she plans to do in the future. By shedding past life beliefs and attitudes and enacting out a new narrative the person is free to move forward in a new direction.

"And you do, you analyse yourself and it just unfolds in front of your eyes which is what happened to me. All the things that I'd blocked to stop myself from hurting, or going back to your childhood, you realise there are lots of things still unresolved (counselled respondent)."

Mattingly (1998:8) maintains there are three features that make narrative appropriate in the healing experience. Firstly narratives are 'event- centred' and concern human action and interaction. Secondly narratives are 'experience centred', allowing patients to recount

what has happened in their lives. And thirdly, "narratives do not merely refer to past experience but create experiences for the audience (ibid.)." Turner (1987) also speaks of the performance value of social drama and narrative, maintaining that all humans are essentially performers who learn more about themselves through the enactment of life events.

"If man is a sapient animal, a tool making animal, a self-making animal, he is, no less, a performing animal. Homo performans, not in the sense, perhaps, that a circus animal may be a performing animal, but in a sense that man is a self-performing animal - his performances are, in a way, reflexive, in performing he reveals himself to himself (Turner 1987:81)."

Schechner (1995:28) discusses the theories of Goffman who makes a distinction between types of performer. Apart from professional performers, who master the techniques of performance and get paid for it, there are two other types; those who know they are performing and conceal it, like comedians, and those who do not know they are performing. The latter type of performers are further divided into two subdivisions; those who are caught on camera for television programs such as *Candid Camera* and the News; and ordinary people playing their every day life roles as they go about their functions at home and at work. Schechner explains the possible consequences for both these types of performer in the event of a tragedy. - The woman whose children have perished in a fire pours out her grief and bewilderment in front of the cameras and the public will later watch her performance on the News broadcast. Later she watches replays of her own grieving. Another woman in a similar plight does not make the News headlines. The consequences might be that the woman whose performance is broadcast is likely to be offered assistance by sympathetic viewers, whereas the un-broadcast woman will have to rely on her own resources (ibid.). Of course, it might also be the case that the woman who was broadcast does not receive offers of help so would she then be in the same position as the un-broadcast woman? Schechner does not elaborate on this scenario but according to Turner's theory, the woman who performed for the cameras would have learned more about herself through the enactment of the event.

According to Lindquist (1997:110), cultural performances have the power to transform the experience of respondents and spectators alike, creating new meaning and altering social structures. Some techniques used in counselling, outlined by Edgar (1995:6) as

psychodrama, sculpting, gestalt, dream work, imagery work and artwork, are designed to create transformation in respondents by allowing aspects of their deeper hidden emotions to be consciously transformed into narrative format. Jennings (1992) suggests that ‘drama therapy’ is a means of making imagination into words; dramatic action that is embodied and vocalised is projected into images and then dramatised. By the physical enactment of emotional reactions to certain situations respondents can become aware of psychological impressions about themselves that were previously hidden. Turner (1982:87) states that narrative and cultural drama may have the task of remaking cultural sense in a world that seems to be tearing down traditional edifices of meaning. However, Mattingly (1998:107) argues that contrary to the majority of anthropological assumption, that what narrative offers to the structure of experience is coherence, is more likely to be the need to locate a ‘desire’ in the patient to find a new course or *telos* in life. In her experience therapists battle hardest with patients who are despondent and have lost direction and understanding of life.

“I was thinking, women lose babies all the time and get on with their lives, why is that not happening to me, why can’t I just think well it was meant to be, like everybody was saying to me.....She just brought everything into line for us, didn’t she? (counselled respondent)”

“I think for me counselling helped me get my life back on track. You know when it happens you feel as if your whole world is at end, well you don’t know what to think really (counselled respondent/focus group).”

It seems quite incredible that people who are in the depths of despair can regain the desire to continue with their lives just by constructing a narrative of their perceived experience but Mattingly explains that narratives have a beginning, a middle and an end and we humans have a need for ‘endings’, even if the ending is an ‘explanatory fiction’ and is meaningless in the real world.

“Narratives give us various fictions of the end, ‘though the end is like infinity plus one and imaginary numbers in mathematics, something we know does not exist but which helps us to make sense of and to move in the world’ (Kermode 1966:37 in Mattingly 1998:37).”

Because a pregnancy has not ended as expected, with a new addition to the family unit, bereaved parents need to formulate another ending to their narrative, one that allows

them to adopt an innovative attitude to life. However, Mattingly says there is a great deal of controversy amongst writers, especially amongst literary theorists, concerning the difference between narrative and lived experience since narrative is not representative of real experience and can be narrated differently every time it is recounted, even by the same person. Therefore the narrative of an experience is a narrators' own perception of that particular experience and not necessarily a true representation of the event (ibid.). But Kleinman (1988:50) contends that 'retrospective narratization' is frequent in circumstances where there has been a catastrophic end to a situation and in these instances narrative may hold a moral purpose. In accordance with Turner (1967), Kleinman proposes that;

"retrospective narratization acts something like the recitation of myth in a ritual that reaffirms core cultural values under siege and reintegrates social relations whose structural tensions have been intensified. Illness narrative, again like the ritual use of myth, gives shape and finality to loss (Kleinman 1988:50)."

The action of secular ritual is said by Myerhoff (1977:24) to be a soothing expression of 'potence and optimism' in situations of inadequacy, danger, and anxiety. Myerhoff (1990:246) maintains that ritual, like narrative, alters the ordinary state of mind by overcoming barriers of thought, action, knowledge, and emotion, bringing about transformation that is multi-dimensional by fusing together the dreamed-of, and the lived experience. The performance of ritual shares some similarity with counselling in as much as it seeks to alter how people experience themselves in the world, including people around them, their surroundings and life circumstances (Laderman & Roseman 1996:94). With psychoanalysis or counselling the transformation is seen as part of a reflexive process that integrates disruption and restores continuity in life.

The exact definition of ritual is a matter of discussion amongst anthropologists, with Turner (1967) suggesting that the term ritual can only be applied to religious ceremonies or mystical experiences, and others alleging that all activities have ritualistic qualities (Humphries & Laidlaw 1994). Although Turner (1967) defined ritual as "formal behaviour for occasions not given over to technological routine, having reference to beliefs in mystical beings of power", in 1968 Turner changed this definition of ritual to read, "having reference to beliefs in mystical (non-empirical) beings of power."

However, he added that ritual might be defined "as a corpus of beliefs or practices performed by a specific cult association (in Humphries & Laidlaw 1994:82)." Since not all cult associations believe in non empirical beings Humphries and Laidlaw assert that Turners' woolly description of ritual is because he cannot bring himself to write 'imaginary' instead of 'mystical'; a word that does not apply to all rituals. In Humphries' & Laidlaws' (1994:71) view, ritual is a quality that can apply, in theory, to any kind of action, whether or not it is religious, performed by specialists, performed regularly, or expresses the social order. According to La Fontaine (1972:xvi) rituals exemplify in verbal expressions, or statements of belief, cultural values about the world, society and humans.

Comer (1996:23) states that it is through ritual that 'realms of meaning' are created. On one level ritual is an expression of nostalgia for the lost worlds of the womb, the breast and childhood, and this nostalgia for 'paradise' is common to all human groups. "Nostalgia for lost worlds spurs us onward to an imagined future that is really an idealised past (ibid:40)." According to Comer, modern politicians know this and deploy this knowledge in a practical way by promising to reclaim national greatness, Hitler being a prime example. What is not readily recognised by many people is that the world at large is constructed and maintained through ritualistic means in both traditional and modern societies but the complexity of the modern world makes these rituals 'strenuous theatre'. Modern ritual can be found in all sectors of modern society, business, law, academe, politics, medicine, and the specific training that is required for these theatrical roles in society is only available to certain people. Those excluded from meaningful participation have to find a basis for identity elsewhere or fall into *anomie* (ibid:46). If one loses identity in the theatre of life, and is therefore out of control, then a feeling of being in control must be 're-embedded' and the reality of one's own environment established. This same hypothesis might be true of women who fail to perform their socially designated role of child-bearer; that they are excluded from meaningful participation in society until a new reality of environment is established.

Van Gennep, who Turner (1995:166) refers to as the father of 'processual' analysis, describes a ritual as having three phases of passage that take respondents from one culturally defined state or status to another. Van Gennep distinguishes between the

structural and symbolic aspects of ritual, using the terms *separation*, *margin* and *reaggregation* to describe the former, and *preliminal*, *liminal*, and *postliminal*, when referring to spatial or time transitions in which behaviour and symbolism are seen as being peripheral to the social structure of a culture. With the process of counselling the client might be seen to move through all three phases of ritual, both from a structural and spatial perspective. The client feels physically separated from society because of their embodied experience and resides mentally in a spatially liminal state where they are unable to move on, either physically or mentally, until eventual re-aggregation into society takes place through counselling. Turner discusses liminality in everyday life, stating that liminal or marginal people are those who live on the edge of society, both physically or mentally, striving to rid themselves of their status of incumbency, or inferiority, and to form *communitas* with the rest of society. However, he believes that being in a liminal or marginal state has its advantages, since not only does it provide a ‘template’ for one’s relationship to society, nature and culture, but also has the capacity to incite people to thought as well as action. It is while in this liminal state that those who are despondent find the necessary ‘desire’ to create life anew, as suggested by Mattingly (1998:107).

3:5 The Critics of Counselling

Nevertheless, counselling, healing rituals, drama therapy, and the like, might not always work to liberate a client to a new existence but the failure rate of these therapies is rarely, if ever, discussed by writers or practitioners. Many social scientists claim that counselling is nothing more than a waste of time and money and a potentially harmful one at that. Dr. Bruce Charlton, lecturer in psychology at Newcastle University, believes counselling is a brainwashing technique that induces dependence of the client on the therapist. The ‘Counselling Cult’, as Charlton terms it, is initiating vast numbers of converts who acclaim the benefits of counselling even though, in his opinion, it is a placebo therapy with no remedial effect (Charlton 1998). When contacted by email Dr Charlton made the following comment about counselling:

“The lack of specific effectiveness of psychotherapy and counselling is uncontroversial in informed circles – therapists and counsellors have never been able to show any benefits of training, or of theoretical expertise. There is no justification for a ‘profession’ of therapists (Charlton 1999).”

Moreover, Charlton contends that since people accept counselling as 'a good thing' a scenario could be set up that is particularly dangerous and harmful to clients. He questions the motives of counsellors believing them to be dubious because counsellors are often "drawn from people who themselves have experience of psychopathology." Dr. Myles Harris, a London general practitioner is also opposed to counselling, especially when it is available on the National Health Service, which he equates to a 'state-licensed friendship service'. Harris's main bone of contention, like Charlton, is that as yet nobody has been able to demonstrate counselling's effectiveness in a way the efficacy of penicillin might be demonstrated (in Williams 1999). Although counselling is fast becoming an everyday fact of life, especially in the West, Arnason's (1998:125) assumption that critics of counselling see it as essentially 'oppressive' and as a social mechanism to suppress the freedom of clients, appears to be accurate.

But is counselling something that has to be performed by the National Health Service or by a qualified practitioner? Reddy (1996), himself a counsellor, says that although counselling is often described as a profession, which in the last analysis means it can only be performed by qualified members who supposedly have some level of superiority or legal sanction, it is in fact something which occurs spontaneously in nature and that ordinary people, although often unwittingly, are counselling each other all the time. Reddy therefore questions whether the present assertions concerning counselling are parallel to the story of the Emperor whose loyal subjects admired his new clothes even though they were non-existent. Hodgkinson (1992) too is of the opinion that counselling does not always have to be provided by professional counsellors. He believes that at its most simple, counselling is talking to someone outside the family circle who is willing to listen, the premise being that discussing one's problems will help us cope better with the dilemmas of life. "People have been listening to the problems of other people since the dawn of time and without any special qualifications apart from being human (ibid.)."

But perhaps there is some reason, other than that of helping people come to terms with traumatic circumstance, which has furthered the present interest in counselling. Cunningham (1999) implies the impetus for the huge expanse in counselling is not because of its therapeutic effect at all but because of government handouts. Cunningham

states that in 1990, following a government decision to reimburse up to a hundred percent of the hiring cost, general practitioners began employing professional counsellors to work with their patients. In the light of the recent eruption of counselling onto the social scene in the UK, Cunningham asks, have the numbers of counsellors risen because its therapeutic effect has increased the demand for counselling? Or do people feel they need counselling because counsellors are available free of charge from the National Health Service?

Nevertheless, even though not everyone endorses the practise of counselling, it seems that various forms of therapy have been around for some time, from the psychoanalytic method of Freud in the early 1900s to the more modern approaches that include psychodrama and gestalt. The one thing that these therapies appear to have in common is that they are performance related techniques that allow patients to act out their own particular scenario of suffering in the hope that their old narrative of life can be exchanged for one that will be more supportive to them in the future. Because the efficacy of all counselling techniques rely upon their ability to bring about a change in consciousness in patients, some writers (Kleinman 1988; Myerhoff 1977,1990) have likened counselling to ritual, since ritual too is said to help participants overcome thought barriers and bring about a transformation of awareness.

Since the reaction of women to pregnancy loss in the West might be due to a legacy of the understanding and experience handed down from the past, when women were blamed for a loss, and more recently, encouraged to believe the performance of their body was less than ideal, then it could be argued that ultimately a change in the present cultural narrative of our society would be the best solution to the present crisis. It might also be said that this is exactly what women who have been counselled following pregnancy loss are in the process of doing. By changing their personal narrative women may eventually force the hand of society as a whole, the outcome of which could mean a change in the cultural narrative of western society toward pregnancy loss in the future. With an awareness of the complexities of pregnancy loss and of counselling in mind the evaluation of the counselling service at South Cleveland Hospital is presented over the next three chapters, beginning with an overview of the geographical location of where the evaluation took place.

Chapter Four

An Overview of Teesside and the Research Carried out at South Cleveland Hospital

4:1 *Setting the Scene*

South Cleveland Hospital is situated in Middlesbrough in the North East of England and is part of South Tees Acute Hospitals Trust. However, providing quality health care in Teesside has never been an easy task, mainly because of the changing social circumstances of the region over the last century that has resulted in health inequalities when compared with other parts of the country. Although Middlesbrough is now one of the largest towns in the North East of England it was relatively unknown until Victorian times. In 1862, William Gladstone described Middlesbrough as “the youngest child of England’s enterprise but an infant Hercules (Briggs 1968).” At the time of Gladstone's prognosis the infant had already began to show the first signs of adolescence; having developed from a small community of just twenty five people living in four houses in 1801 to a small town with a population of 19,416 at the census of 1861. During the ensuing decades, as Gladstone had predicted, Middlesbrough developed into a veritable giant with 91,302 inhabitants by 1901. But the rapid population growth of Middlesbrough, due to the progress of the iron and steel industries throughout the North of England, introduced new dilemmas to the area in the guise of poor housing conditions and low standards of health care (Briggs 1968). The chart below shows the population of Teesside in 1996.

Fig.1a

POPULATION OF TEESSIDE 1996 (TEES HEALTH AUTHORITY 1999)					
Variable	Middlesbrough	Stockton	Hartlepool	Redcar & Cleveland	Total Teesside
Population	145,020	177,610	91,270	141,140	555,040

Throughout the twentieth century the population of Teesside continued to grow and several hospitals were opened to meet the ever-growing demand for medical services. In recent years some of these hospitals have become obsolete, but South Cleveland Hospital,

Middlesbrough General Hospital, and North Riding Infirmary banded together to form the South Tees Acute Hospitals NHS Trust established in 1991. As one of the largest hospital trusts in the UK, it offers a wide range of specialist care services to over 1,000,000 people living in and around Teesside and parts of Durham, North Yorkshire and Cumbria. However, after a detailed appraisal of the quality and efficiency of the Trust, it was concluded that continuing to spread the services over three sites is not in the best interests of patients. Therefore preparations to move all thirty-three medical specialties presently functioning across three sites to a single site at South Cleveland are currently underway. According to the Trust the reconstruction of the South Cleveland site will create a new hospital designed to meet the demands of modern medicine and patients' needs into the 21st century. In conjunction with the changeover to a single site the Trust have developed a strategy which takes into account what is happening 'politically, economically, socially and technologically around it'. It is committed to achieving better outcomes for patients from their treatment even in the face of increasing demand for services fuelled by the poor health that is experienced by many Cleveland residents (Tees Health Authority 1999).

Enormous improvements have been made in the safety record of maternity services both at South Cleveland and in the rest of the country during recent years. Records indicate that in 1960 in England and Wales, thirty babies in every thousand births were stillborn, or died within the first week of life but by 1992 the figure had fallen to six in every thousand (*Changing Childbirth Report 1993*). Records also show that in 1998 the total number of registered births for the combined communities of Middlesbrough, Hartlepool, Redcar & Cleveland and Stockton was 3,477 with 24 stillbirths; just less than seven in every thousand. However, although these figures appear comparable with average national figures for stillbirth a report from the 'Tees Health Authority' (1999) suggests that figures representative of the whole of Teesside do not necessarily reflect the true figures for individual communities within that area. For example, in 1996 the infant mortality rate (IMR) for the whole of Teesside was estimated as being 1 in every 166 conceptions, which is comparable with the national figure of 1 in 200. But when figures from individual communities of Teesside are looked at they reveal the total number of infant deaths for Middlesbrough in that year to be far higher than those in the surrounding communities of Redcar & Cleveland, Hartlepool and Stockton. The ratio for infant

deaths to conceptions for Middlesbrough was 1:100, Stockton 1:148, Hartlepool 1:328, and Redcar & Cleveland 1:398. (See Fig. 1b & 1c)

Fig.1b

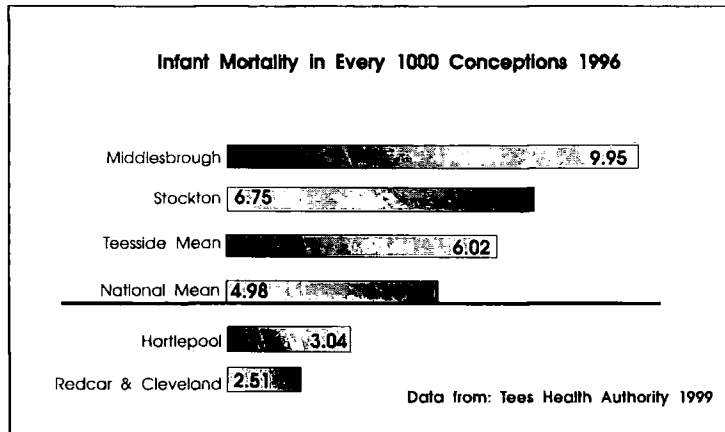
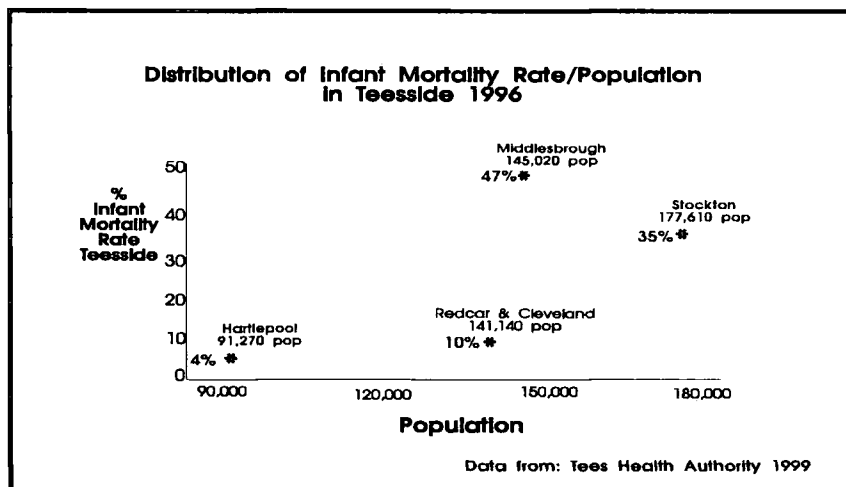


Fig.1c



Although it would not necessarily follow that the distribution of the Infant Mortality Rate (IMR) of an area is an accurate reflection of the Foetal Mortality Rate (FMR) there is some evidence to suggest that this might be true of Teesside. Of the one hundred patients who were originally chosen at random to take part in the study 81% lived in Middlesbrough and 19% in surrounding areas. This suggests that like the distribution of the IMR (as published by Tees Health Authority) there is a possibility that the FMR is also unequally distributed across the Teesside area. But this could only be accurately ascertained if the personal details of all hospital patients were examined in detail, which is beyond the scope of this study.

According to 'Tees Health Authority' despite recent investments, initiatives, and the development of first class health care services, overall health and well-being in some areas of Teesside remains extremely poor. The Black Report, a study of inequalities in health, suggests that one reason for the divergence of the IMR in communities such as Teesside might be due to occupational class differences of parents. Rates of stillbirth and death in the first year of life increase progressively from occupational class I to class V; class I being professionals, such as lawyers, doctors and accountants, and class V being unskilled manual workers (Townsend & Davidson 1992). Higher incidences of stillbirth were also found in babies born to parents living in rented accommodation compared to owner-occupiers (ibid.). Studies in midwifery and the social sciences show it is not only occupation that affects pregnancy outcome but also socio-economic factors too (Symonds & Hunt 1996). According to Briggs (1968) the IMR of an area is a reflection of the amount of social control within that area. Although unemployment figures are high across the whole of Teesside the IMR of the individual districts differ drastically, which might suggest that it is the social problems combined with high rates of unemployment or low paid employment that are the cause of the higher IMR of Middlesbrough.

Fig. 1d

Unemployment Rates on Teesside Compared with National Average June 1998					
Hartlepool	Middlesbrough	Redcar & Cleveland	Stockton	Teesside Average	National Average
10.8	9.5	9.0	7.2	9.1	4.5
4101	6495	4872	6347	21,815	1266,046

Fig. 1e

Infant Mortality Rates on Teesside Compared with National Average 1996					
Harlepool	Middlesbrough	Redcar & Cleveland	Stockton	Teesside Average	National Average
3.5	11.9	2.9	7.6	7.0	6.1
4	23	5	17	49	3736

Tees Health Authority 1999

The '*Tees Health Authority*' proposes that to have lasting effects on health patterns in Teesside it is not only the high rates of unemployment and poverty that need to be addressed but also other underlying causes such as 'lifestyles, social inclusion and community safety'.

One of the services provided by South Cleveland Hospital, affiliated to South Tees Hospital Trust to combat the social deprivation of the area is the bereavement counselling service for parents who experience pregnancy loss. The impetus for the counselling service came in 1993 when it was recommended by the '*Changing Childbirth*' Report, that in the event of pregnancy loss patients should not only be given practical support but also be offered counselling to alleviate the emotional anguish that often accompanies a failed pregnancy. Following this recommendation, midwives at South Cleveland Hospital became qualified in counselling skills and began counselling patients who had experienced miscarriage, stillbirth or termination for foetal abnormality. Since that time the counselling service has undergone several changes in an attempt to utilise the valuable time and resources of midwife/counsellors to the maximum and to ensure that patients have access to a quality counselling service. Inasmuch as the demand for counselling following pregnancy loss has increased over the last year, and because South Tees Trust is committed to better outcomes of treatment for patients, the 'Women and Children's Division' at South Cleveland Hospital (SCH) requested that an evaluation be carried out to ascertain the need and efficiency of the counselling service offered by the midwives.

4:2 Methods

In September 1998 a midwife from South Cleveland Hospital requested that an evaluation be carried out of the counselling service that she and her fellow midwives offer to patients who suffer a pregnancy loss. The midwife voiced concerns that although she and her fellow midwives believe the service is of great benefit to bereaved parents several of the consultants were not of the same opinion, believing that any money available could be spent on more pressing needs such as medical treatments which might be of more benefit to patients. In October 1998 the outline proposal for the evaluation was submitted to the ethics committee of South Cleveland Hospital. Because the topic of pregnancy loss is a sensitive issue the ethics committee felt that the re-opening of old wounds could be potentially upsetting for patients so they needed to ensure the research

was carried out in a manner that would cause the least distress possible to patients. The proposal was modified to meet with the ethics committee's requirements but identifying the correct approach to the research was a lengthy process, mainly because committee members only meet once a month and there were many ethical issues to consider. Eventually, together with the Manager of the Division of Women and Children the main aims and objectives of the evaluation were identified as follows;

- to estimate the necessity for the bereavement counselling service offered by the midwives at South Cleveland Hospital in the event of pregnancy loss and the accessibility of the service to patients;
- to consider if patients should be approached by a counsellor in the event of pregnancy loss or whether patients should request counselling if and when they feel they need to;
- to identify the advantages and disadvantages of the midwife as counsellor in pregnancy loss;
- to appraise the benefits, if any, that patients derive from counselling and the optimum time when counselling should be made available to parents;
- to discover if family members might benefit from counselling and who should administer that counselling, i.e. midwife, independent counsellor, GP etc.;
- to determine how the service at South Cleveland compares with counselling services at other hospitals and fits into the wider network of services in the area;
- to assess the demand for counselling and any possible long term effects of the counselling service;
- to describe recommendations offered by patients and professionals to improve the present or any future counselling service at South Cleveland Hospital.

In January 1999 the proposal was accepted and I was given access to the hospital records of women who experienced pregnancy loss between 1994-1998. The names of patients who received counselling were identified from the record of appointments in the diaries of the midwife/counsellors. Letters requesting them to take part in the study were sent to one hundred patients. Fifty patients had received counselling following their loss and fifty patients had not received counselling but were chosen to act as a control group. Patients who were willing to take part in the study were asked to sign and return the consent form giving permission to contact their general practitioner. Twenty-nine replies were received, nineteen from patients who had received counselling and ten from control group respondents. General practitioners were informed of patients' intentions to take part in the study and were asked to respond if there were any objections to this. Prospective respondents were contacted by telephone to arrange a convenient time and place for an interview. Two respondents did not want to be interviewed but requested that comments

made by letter be acknowledged in the report. One patient asked to attend a focus group meeting but did not want to be interviewed personally. Four of the original respondents from the counselled group and one from the control group eventually withdrew from the study for personal reasons.

Fig. 1f

Birth Statistics for 1996 to 1998 South Cleveland Hospital

Year	Live Births	Stillbirths	Termination Foetal Abnormal	Counselled Patients
1996	4369	17	25	20
1997	3902	23	25	18
1998	3684	24	27	30

Fig. 1f. shows the birth statistics at South Cleveland Hospital between the years of 1996 and 1998. Although the live births have decreased, stillbirths and terminations have increased slightly along with the number of counselled patients.

The data-collecting element of the study was under the authority of South Cleveland Hospital whose remit it was to access information that might answer concerns related to the need and efficiency of the counselling service. Because the respondents who took part in this study are patients from South Cleveland Hospital, many of whom had been traumatised to varying degrees following the loss of a baby, the hospital management and the ethics committee had authority over the format and content of the study. All questions asked during interviews with patients were discussed with the Manager of the Division of Women and Children and approved of by the ethics committee before they were incorporated into the study.

From the point of view of an anthropological study I felt the questions I was permitted to ask respondents were limiting, since I was not at liberty to ask questions that might have yielded more anthropological data. But because human beings are what they are, having a tendency to elaborate on the details, much ethnographically rich data was collated during the interviews and focus group meetings even though the questions were originally

designed to satisfy the hospital's remit. As was explained earlier, because of the nature of the study every precaution was taken not to upset patients any further than necessary. No information about the medical causes of loss or their personal circumstances was sought from patients, however some patients offered this kind of detail during the course of the interview. The researcher herself, although having a good deal of experience in birthing procedures after giving birth to her own four children, has no experience of miscarriage, stillbirth or termination for foetal abnormality and therefore is not emotionally implicated with the subject.

4:3 Interviews

Fieldwork commenced in February of 1999 and data was collected using both qualitative and quantitative methods of research. Thirty-eight personal interviews were carried out with patients and professionals. Personal interviews were decided upon as a method of data collection because face-to-face contact with respondents allows the researcher to elicit information about the subject that could not be accessed by questionnaire. Sixteen interviews were carried out with respondents who received counselling, nine with respondents from the control group, and thirteen with consultants, midwives and managers. Most interviews with patients took place in their own home, although some were carried out at the hospital. All interviews with professionals took place in the hospital.

Although there are several approaches to interviews it is the 'general interview guide approach', as suggested by Patton (1990), which is adopted in this study because of its flexibility. With this method of interview respondents are given an outline of issues to be explored before the interview commences and the interviewer adapts the wording and sequence of questions in accordance with developments during the interview. This particular interview technique makes the data collection systematic for each respondent and allows for gaps in the data to be closed. However, because this method of interview regulates the topics of conversation to a certain extent, it may mean that on occasions salient topics are inadvertently missed. Also the flexibility of the wording might result in each interviewee having a different understanding of a particular question. Nevertheless, a more standardized set of words and questions could constrain and limit the naturalness and relevance of questions and answers whereas a more autonomous approach might

render the data ineffectual (Patton 1990). The personal interviews with patients were carried out before those with professionals so that the researcher would have no preconceptions concerning the expectations of the professionals regarding the counselling service.

Most of the questions presented to patients were relevant to some aspect of the counselling service and were designed to find out their views on the service itself, the competence of the counsellors, and impressions of other medical personnel that patients had come into contact with during their hospitalisation. The only questions posed to patients that were not relevant to the aims and objectives of the hospital's remit were designed to find out about respondent's family ties and their thoughts on counselling in general. In addition, control group respondents were asked how they had come to terms with their loss without the aid of counselling. Although questions put to patients during interviews were subject to screening by the ethics committee those presented to professionals, both during interview and by questionnaire, were devised by the researcher and designed to establish the professional's views on the credibility of the practise of counselling and their understanding of the counselling service presently offered to bereaved patients at the hospital. A resume of the questions asked to both patients and professionals during personal interviews can be found in Appendix 2, Fig. 2a, 2b, 2f, & 2g. These are designed to answer the criteria of aims and objectives of the study, outlined on page 49.

4:4 Focus Groups

Two focus group meetings were arranged with counselled respondents and were carried out at the hospital. Although focus-group meetings give less information about individuals they can produce data that might not be accessed during an interview where the line of questioning is regulated. Focus group meetings were included in the study because, according to Morgan (1997), although focus groups require a greater amount of attention by the moderator and provide less depth and detail than personal interviews, they supply direct evidence about similarities and differences of participant's opinions and experiences. Morgan maintains that personal interviews and focus groups can be complementary to each other and that preliminary personal interviews can be useful in indicating whether or not people from different ethnic, cultural or class backgrounds

would be compatible in a group situation. Likewise preliminary focus groups can provide a useful starting point for individual interviews, giving the interviewer an opportunity to learn more about the range of informants.

Bernard (1995) suggests the real power of focus groups is the ethnographically rich data they produce which can be captured only by full transcription of recorded meetings. He recommends that ideally focus groups should have around eight members plus a moderator. If the group is too small, below six, one or two people with strong opinions may dominate the proceedings. If too large, say over ten, the group might be difficult to manage and could present difficulties when transcribing the tape recording if several members of the group spoke at the same time; this is especially true when respondents are highly involved in the topic. Morgan (1997) discusses the need for several groups in a study. He says this is 'implicit in the criterion of saturation' because it is necessary to compare discussions from more than one group to determine if respondents are repeating what other groups have said. With only one group it would be difficult to tell if the discussion reflected either the unusual composition of that group or the dynamics of that unique set of respondents. The data from two groups will be acceptable if both groups give similar information. If the two groups give different information it would be fair warning that saturation has not been achieved and further focus groups should be arranged. The group should be encouraged to discuss the relevant issues, however, the moderator must be open to other issues arising during the meeting, as these might provide valuable information. The counselled respondents who took part in the two focus groups that were carried out in this study gave similar impressions of the counselling service therefore it was concluded that saturation had been achieved.

The two focus groups were informal, supportive and non-judgmental (Morgan 1997) and were carried out to complement the data gathered by personal interviews. Group members were all counselled respondents and were of mixed gender and age although the background and social characteristics of respondents were similar (Kreuger 1988). Whenever possible respondents of focus groups were selected from patients who had experienced the same class of pregnancy loss; i.e. group (A) stillbirths and group (B) therapeutic terminations. This offered an opportunity for respondents to explore their thoughts and feelings with their peer group. Although it would have been advantageous

to select respondents from the same year of loss, because valuable information may have arisen peculiar only to a certain year group that may not be raised in mixed year group sessions, this was not possible due to the number of respondents taking part. Neither was it possible to arrange focus group meetings with control group respondents, because of a lack of volunteers, or with respondents from ethnic minority groups since only two respondents from ethnic minority groups took part in the study.

Although sixteen respondents initially agreed to take part in the focus group meetings only twelve kept the appointment. Six respondents and myself as moderator attended each of the two focus group meetings. At the time of the interviews and focus group meetings patients were asked to sign consent forms indicating their agreement to the interview and/or the focus group meeting being tape-recorded. Both of the focus group meetings and all interviews were recorded, apart from one with a consultant and two with patients. Extensive notes were taken throughout these interviews. The tape recordings of all interviews and focus group meetings were later transcribed giving a total word count in the region of 80,000 words.

4:5 Questionnaires

A questionnaire was devised to ascertain the general attitude of medical professionals toward the practise of counselling and to determine how many medical professionals have any counselling skills or qualifications. Two hundred questionnaires were distributed to hospital staff after an initial pilot study was carried out with midwives from the Day Unit in order to verify that the questions asked were understandable and would gain access to the information sought after. Questionnaires were not given to patients because the hospital ethics committee felt that completing a questionnaire when a doctor or counsellor was not monitoring patients for their reaction could trigger an emotional response that might go undetected. Of the two hundred questionnaires distributed to hospital staff only forty-five replies were received. These were from thirty-nine midwives, three healthcare workers, two doctors and one ward clerk. The main difficulty with questionnaires is to obtain an adequate response rate, especially if the researcher is not present while the respondent answers the questions. According to Morgan (1997) the typical response rate for a mail questionnaire without follow-up is between 20 and 40 percent, which raises the issue of how to estimate the effect that non-respondents would have had on the findings.

Respondents who did reply are not likely to be an accurate representation of the whole of the medical personnel at the hospital, which will undoubtedly add bias to the study.

Although questionnaires are not the best method of research for gathering in depth information from respondents they are useful in some respects; the interviewer is not able to influence respondent in any way, there is a high degree of anonymity for respondents, the respondent has time to think of answers, and they provide a wider access to geographically dispersed samples. However, the disadvantages with questionnaires is that only simple questions can be asked, the researcher cannot probe for additional information and has no control over who fills out the questionnaire.

4:6 Data Analysis

The data analysis phase of the work involves the search for patterns in the data. Data from the questionnaires was analysed using the computer program SPSS. Data from the focus groups and interviews was coded and put into table format. Similar statements given by respondents were numbered, as suggested by Bernard (1995), because this system allows data recorded by qualitative methods to show repetitions of answers. However, Morgan (1997) argues that an attempt to understand a group's activities as no more than a sum of the behaviours of its individual members amounts to the well-known fallacy of 'psychological reductionism'. In his opinion neither the individual nor the group constitutes a separable 'unit of analysis' and that analytic efforts must seek a balance that acknowledges the interplay between these two levels of analysis.

“The real issue or argument concerning the coding of qualitative data is not whether qualitative researchers want to characterize the difference between groups but whether numerical characterizations of those differences add anything to our understanding (ibid).”

The researcher feels that numbers might add little to the meaning of thoughts and feelings on certain issues (pregnancy loss being one of them) because numbers do not take into consideration the actual emotional state of the respondent at the time of the trauma or the interview. Therefore the quality or depth of the data was not sacrificed in favour of the numerical breadth, although the main patterns that emerge from the study are coded according to the methods cited above. Information given by consultants, midwives and

managers during interviews and from questionnaires was coded, outlining the professional's impressions and expectations of the counselling service and recommendations for any future service.

4:7 Ethics

Ethical considerations are of paramount importance in this study because pregnancy loss is a sensitive issue. For many patients the loss would have occurred up to five years previously and asking patients to think about how they felt at the time of their loss would re-open old wounds. There is also a risk to patients who were more recently bereaved since they could be more traumatised by recalling to memory the very incidence they are trying to forget. For this reason patients' emotional reactions were carefully monitored and all patients were offered an appointment for counselling with the hospital midwives if they were upset in any way by the interview.

Every precaution was taken to preserve the anonymity of respondents and to keep in confidence any information given to the researcher. Nevertheless it is very difficult, if not impossible, to measure how ethical any research proposal might be since research which is regarded as ethical today, could well become unethical tomorrow (Bernard 1995). However, the ethical concerns of the four C's' of ethical research, as recommended by Sanders and Liptrot (1993), are observed throughout the evaluation:

Competence; working within one's own limits and asking for help when unsure of anything.

Consent; obtaining informed consent from the participant and making sure they fully understand what they are agreeing to, who the researcher is, and the nature and purpose of the study.

Confidentiality; ensuring that respondents in the study cannot be identified and that all records are kept safe where no one else can gain access to them. All records are to be kept secure and destroyed when the study is finalised, in accordance with the Data Protection Act.

Conduct; making sure that respondents are not put at risk and the researcher is able to justify the study to both self and others and is prepared to abandon the study if necessary (ibid).

According to Sanders and Liptrot (1993), informed consent is the foundation of ethical research because it gives respondents information regarding the research and most importantly the opportunity to decide whether or not to become involved. Respondents were given written information explaining the basis of the study and informing them that they could withdraw at any time. Respondents were also asked to sign two consent forms, one indicating their willingness to take part in the study and to give permission for their general practitioner to be contacted, and the second for permission to record the interview.

4:8 Summary of Key Findings

The findings of the evaluation were presented to South Cleveland Hospital in a written report in January 2000 and were discussed with medical personnel at the hospital following an oral presentation of the findings in April 2000. This time span for the evaluation was longer than anticipated because of ethical considerations that had to be strictly adhered to. The study reveals the following key findings with regard to the efficiency of the counselling service.

- The process of referral within the hospital of patient to counsellor is a very haphazard procedure; therefore not all patients have the same access to a counsellor following a loss.
- If patients have not been introduced to a counsellor before leaving hospital 62% of the counselled group and 55.6% of the control group said they would find it embarrassing to contact a counsellor to request counselling at a later date.
- Of the counselled respondents 56.25% and 100% of control respondents were not introduced to a counsellor before leaving hospital.
- The majority of respondents from both the counselled and the control groups believe a midwife/counsellor, as opposed to an independent counsellor, should be available to counsel patients at all times, especially patients who are diagnosed with foetal abnormality.
- Of those respondents who received counselling 81.25% were of the opinion it has helped them come to terms with their grief.

The midwife/counsellors at South Cleveland Hospital are all qualified to diploma or advanced diploma level in counselling and are adequately equipped to counsel patients and their families who experience stillbirth, spontaneous miscarriage or termination for

foetal abnormality. All three counsellors use the facilitative or developmental style of counselling explained by Murgatroyd (1996); where patients are encouraged to discharge emotions and reach their own realisation of appropriate action.

Nonetheless, the study shows that a high percentage of medical professionals have no counselling qualifications, even though they are constantly ministering to traumatised patients. However, there is a significant difference between the numbers of community workers as opposed to hospital-based workers in terms of those with counselling skills. Of the sample of 45 questionnaire respondents and the 13 medical professional interviewees, 70% are hospital based and 30% are community workers. While 47% of community workers have some training in counselling, it was found that only 10% of hospital-based professionals had any formal counselling skills or qualifications. Of course the majority of medical professionals working in the community are nurses and midwives while the hospital workers are mainly consultants and managers. This result could be an indication that professionals working in the community are more aware of patient's needs, or that hospital professionals do not consider counselling skills an important aspect of their job.

At the start of the research I was unaware of the lasting grief that some parents endure following pregnancy loss but as the study progressed the true gravity of the situation began to emerge. Although around one in every four pregnancies does not reach full term there is little acknowledgement of this in the popular literature on pregnancy; literature that women might buy when they first discover they are pregnant, or of the possible life long affect that pregnancy loss can have on its casualties. During the personal interviews some respondents found it disturbing to re-live the experience of their pregnancy loss, even though in some instances it had occurred up to five years previously. Nevertheless, even those who found the questions upsetting decided to continue with the interview in the hope that their efforts would make it easier for other bereaved parents to acquire support in the future. Because many of the respondents were overcome with emotion during the interview I found this part of the research quite strenuous since I was aware that every question asked had the potential of upsetting them further.

I am of the opinion that the quality of anthropological data collated during the interviews and focus group meetings might have been improved upon if I had been given more freedom of choice with regard to the content of the questions. Although I had read extensively on both pregnancy loss and counselling before starting the evaluation this knowledge proved to be no substitute for the experience gained from actually carrying out the research. The discussion presented in the following two chapters provides a more detailed account of the findings of the evaluation, the majority of which was presented in a report to South Cleveland Hospital.

Chapter Five

The Counselling Service at South Cleveland Hospital

5:1 The Background of the Counselling Service

South Cleveland Hospital have had a facility for bereavement counselling since before 1993 but the present service is the brainchild of two midwives who developed further an existing service that was being run on a low key basis. Being of the opinion that following a pregnancy loss some parents need additional support, their vision was to have an integrated team of midwife/counsellors to ensure the availability of a counsellor at the time of a patient's loss. Initially the team consisted of two midwives, who were then studying toward a diploma in counselling, and lay helpers who took responsibility for the administration and paperwork. Eventually a third midwife joined the team who saw counselling as being her main interest and she has since developed that role within other parts of the division. In addition to the advanced diploma in counselling she holds a certificate in couples counselling with *Relate* and is the independent counsellor for assisted conception, affiliated to the *Human Fertilization and Embryo Authority* in London. With the arrival of the third midwife the two original midwife/counsellors felt they could be released from their counselling role to some extent to embark upon a new project in the community. The majority of counselling is now carried out by one midwife/counsellor with the two original midwives assuming the role of counsellor when required to do so. The comprehensive service that was originally proposed, i.e. that a counsellor would be on hand to visit all newly bereaved patients', has not come to fruition mainly because of the lack of support from management, according to a midwife/counsellor.

Perhaps the most active support organisation in the Teesside area, in the event of pregnancy loss, is the charity organisation 'Care for Bereaved Parents' (CFBP) that works between professionals and the community, putting patients in touch with agencies most likely to be of help to them. CFBP operates closely with other charities, including the Samaritans, CRUSE and LIFE and provides practical resources to enhance areas where death takes place or is managed. The Care and Support Worker, who is a representative of CFBP, sees her role as one of mediator between parents and funeral

directors, helping parents make arrangements for the burial or cremation of their baby. She has no medical background but has worked on a voluntary basis for twelve years supporting parents who have lost babies or children. Her job is to visit patients immediately after a loss to inform them of the services available. In essence the support worker helps parents achieve whatever it is that they want for their baby. Some parents need extra time to spend with their baby before saying their final goodbye and others find comfort in having something of their baby that is tangible, such as a lock of hair, footprint or photograph, as suggested by SANDS (1999). The support worker, according to the parents' wishes, does the gathering of mementoes. Although the midwife/counsellors and the support worker are helping in their own way to alleviate the various social problems that can arise with pregnancy loss they do not actually work in unison with each other. This seems to cause confusion for some patients' who believe that the help they are given by the support worker is actually counselling when in fact she works in the capacity of an advisor. The midwives point out that the support worker cannot give counselling to patients because she is not qualified to do so. Nevertheless, patients said their loss was made easier because of the kindness and understanding they received from the support worker, even though she is not a qualified counsellor or a paid member of staff. Perhaps this supports Hodgkinson's (1992) argument that effective counsellors need no other qualification apart from being human.

5:2 Coming to Terms with Failed Pregnancy on Teesside

Respondents, from both counselled and control groups, and their families, expressed appreciation for the counselling service because they believe there has been little support in the past for women who experienced a failed pregnancy. Many women related stories of how pregnancy loss was not discussed openly, even with their partner, family or friends. The concealment of a loss meant that women suffered in silence and coped with consequential grief on their own.

Counselled respondent relating a conversation she'd had with an older woman.

".....'I lost a little boy, you know I had a little boy me first one', and I said did you? 'You know I've got lads eighteen and nineteen now and I'm only telling you this because you have been through it'. I said ee..., I didn't know that at all, and she said 'yes, but we don't talk about it'. I said you mean you didn't? And she said 'well actually we still don't. You know it was my first baby, a little boy'. She went full term with him and he died and she said her husband came home

and got rid of everything that was babyish in the house, 'and I never spoke to him from that day onwards'. And she said 'I had to live with that'. She said even her own husband wouldn't talk about it, and all the family went quiet. 'If I walked into a room I knew they had been talking about the baby, or us as a couple, but they never spoke to me, it was all hush hush. Don't talk about it, forget it ever happened' (counselled respondent)."

Some respondents thought that pregnancy loss had been a 'hush hush' affair in the past because women thought they would be blamed for the loss if they told anyone about it.

"Years ago you were frightened to have a miscarriage because for the simple reason they used to think that you had tried to get rid of it yourself. I don't know if that happens now. Anyone who went in hospital years ago and they had a miscarriage... There was one doctor in there who always said, what have you done? Not just to one person, anyone who had a miscarriage. You know there was a few, and I wanted, you know, I said to him, I hadn't done anything, the doctors been and give me tablets and told me to lay up which I did, and I still had this miscarriage. This sister come in and just took him away, but it was terrible years ago. They thought, you know, because people did use to, you know, but the genuine people who couldn't have them because they just come away and that's it (mother of a counselled respondent)."

Many women spoke of a lack of resources for bereaved parents and the need for more understanding from medical personnel, from people who have never experienced a loss, and sometimes even from their own families.

"So I felt a great lack of support and I wasn't allowed to grieve, I wasn't allowed to talk about it as if he didn't exist (control respondent)."

One respondent said that other people often find it difficult to acknowledge pregnancy loss and that some people try to avoid bereaved parents at all costs.

"A girl across the road went in hospital at the same time as me and she had a baby boy. After I came out of hospital she used to try to hide her baby from me in case it upset me. Every time I went out she would rush away with her baby. I found it very difficult to cope with and the midwife told me to either write her a letter or make conversation with her telling her that I wasn't upset because she had a baby. My husband said he felt like an alien when she quickly shut the door every time she saw us (counselled respondent)."

Some respondents found that keeping tangible reminders of the pregnancy had helped them release feelings of grief. These included photographs, hand or footprints, locks of hair, cot card, name band, stills from scans, a foetal monitor tracing, and so on (SANDS 1999). In the past mortuary memorabilia, or keepsakes of the deceased, were kept out of sight, only for the eyes of parents when they were feeling a little nostalgic about the loss, but in many homes I visited parents had framed photographs of their dead baby displayed in conspicuous positions for all to see. One home in particular had an enlarged photograph of the dead baby above the fireplace. Other families had pictures from ultra sound scans or videos of the foetus or aborted baby.

"My eldest sister was horrified that I'd taken photos of my son when he was dead and that the photos were from a video camera that gave you the photos straight away - a Polaroid- and you couldn't see him on them. So I'd taken a video camera in and videoed him because I needed something of him and my eldest sister was horrified at this, she thought I was sick. I've got photos on the TV of the baby, they stay there because it's my home, and she thinks that's terrible, and she can't believe that I just didn't pull myself together and just get on with it (control respondent)."

The majority of respondents had a funeral service for their baby. The bereavement support worker said it is hospital policy that all foetuses over 12 weeks of gestation are respectfully taken care of, usually by cremation, unless parents request something different, either because of religious beliefs or personal preference for burial over cremation. The bereavement support worker explained how some mothers find it difficult to allow their baby to be taken from them when it is time for the funeral to take place. She has heard horror stories of funeral directors fighting in passageways with mothers or police snatching babies from mothers. However, this does not happen at South Cleveland because the baby is left with the parents for up to forty-eight hours before it is cremated. This gives parents time to adjust to the inevitable. But many respondents felt they had to justify having a funeral for a foetus or an aborted baby to their friends and family who could not understand why they were making such a fuss.

[Respondent talking about her mother] "She came down the day after we came out of hospital, and we were talking about something, and she said 'bloody funerals, they didn't have bloody funerals in my day' and I thought 'yeah, we know what they used to do, you know, but that's just.... I don't know, is it ignorance?' (counselled respondent)"

Although the majority of respondents said they had come to terms with their loss it was evident that the extent of remission differed greatly among respondents and depended mostly on the social circumstances they were immersed in at the time. This is in accordance with Briggs (1969) who found that those living in more prosperous conditions and having vision for the future were more able to move on from an experience with greater ease than those who were in some way financially or socially confined. Some respondents spoke of wanting to move house to get away from the area where they were living but thought this would be impossible, either because their income would not sustain a higher mortgage or they were living on a council estate and stood little chance of being re-housed.

However, although a good cross section of patients from all areas of Middlesbrough were originally invited to take part in the study, few respondents living in what might be considered as truly impoverished areas of the town elected to participate. It is appreciated that the lack of response from those living in impoverished areas will have had an bearing on the result of the study, since it is these people who Townsend & Davison (1992) suggest have lower standards of health, a higher risk of pregnancy loss, and presumably less chance of recovering from the event. Nevertheless, there was little difference between the percentage of respondents from the counselled group and those of the control group in terms of how many lived in Middlesbrough as opposed to surrounding areas. This perhaps is a slight indication that those from more prosperous areas are more inclined to support projects, such as the bereavement counselling service, which might lead to the improvement of health care facilities available to patients in the future.

5:3 Patients' and Professionals' Estimations of the Counselling Service

Although midwife/counsellors believe there is an increasing need for the counselling service at South Cleveland they feel they have not always had the backing of management or their peer group who have on occasions equated it to a 'state-licensed friendship service', as paraphrased by Dr. Myles Harris (in Williams 1999). This is especially true at times when a shortage of midwives and a scarcity of funds make it difficult to carry out

the routine tasks of midwifery and valuable time and resources are not available to spend on counselling.

Most medical professionals agree that ideally if there is a need for counselling then patients should be offered this service but many are concerned about the cost effectiveness of such a service. One consultant suggests that if any funds were available they would be better spent on the majority of women rather than on the small number who might require counselling. Although some consultants admit counselling is an important service and is a part of the active management of patients, many suggest that if added funds have to be put into bereavement counselling then a rationalised business plan is needed to apply for development monies. The midwives' response to this is to point out that since the results of counselling are not always tangible they cannot be audited to produce a set of figures to demonstrate whether or not money has been saved or if better results were achieved because patients had received counselling.

"They'll never know whether a litigation has been averted by the fact that a counsellor has been involved and patients' feel they have been informed and feel that they have been given honest information that allows them to make an informed decision about what happened (midwife/counsellor)."

The cost effectiveness is a high priority for the Trust but it should not be the only consideration when assessing the necessity of a service that might be needed by patients. The therapeutic effect of counselling, that many patients report, is also important (Hindmarsh 1993). All respondents from focus group (A) and four respondents from focus group (B), said the hospital counselling service was a necessity for bereaved parents who lack support from any other quarter of the National Health Services or from society. A patient who contacted the researcher by letter said the midwife/counsellor who visited her after the stillbirth "made that traumatic time easier to cope with and understand." Eighty one percent of patients who received counselling from a midwife reported that coming to terms with their loss was made easier because of the service. Overall the respondents who had received counselling believed that counselling had given them a sense of security and helped them realise that many other parents have experienced a failed pregnancy.

"She helped me understand what had happened. At the time when it happens you feel a bit bewildered and you are not really sure of where you are in life' (respondent/counselled)."

"I felt as though I wasn't on my own. There was somebody out there that I could talk to. She gave me her number and said any time I needed to ring and I did feel that there was somebody out there who could help. And this has happened to other women, not just me. I felt more at ease with the situation just to have some sort of lifeline' (respondent/counselled)."

"I think she helped me more than my family could have, because my husband couldn't understand. My mum was there, she helped me through it, but the rest, they weren't very helpful! (respondent/counselled)."

"Well I found it very useful to be honest. I wouldn't personally have gone in for it myself, if it had been me, but it wasn't just me obviously. But it was good to have someone to talk to about it and answer questions. Tell us things about what had happened. Just having somebody really. Having a midwife counselling was good (male respondent)."

However, the midwife/counsellors do not necessarily promote the counselling service as a cure for anything in particular, "not like being cured by taking a tablet," but rather as an opportunity for people to explore and express what they feel at that time. They acknowledge that counselling is still a developing commodity and that some health professionals do not have an understanding of its true value as a therapy:

"It can be helpful, but I think it is misunderstood by a lot of people, the sticking plaster approach and that, she's got a problem so we'll refer her to a counsellor and that will take the problem away from me, as I don't know how to deal with it. I think that is how it's seen by a lot of people within the Health Service (midwife/counsellor)."

According to a midwife/counsellor counselling is no longer an advisory service that offers 'tea and sympathy' as it used to be but one that allows clients to identify for themselves what is going wrong in their life so that informed decisions can be made about their future. If bereaved parents are willing to work constructively with a counsellor, midwives maintain that counselling can help parents come to terms with their loss in a number of ways.

"Counselling is a service that provides all people with a kind of alternative therapy really. One that can be provided without medication, without

intervention, that allows the person to look at what it is that's going on at the time and give them some control back in their life to allow them to move forward in the way in which they would choose to do (Midwife/counsellor, South Cleveland Hospital, 1999)."

"If they understand that it is a situation where they can explore and help themselves rather than we'll put it right. If they have that understanding of counselling rather than you go and see her and she will have a cup of tea with you and she will be nice with you. If it's done like that, then it's not therapeutic (midwife/counsellor)."

One of the most difficult aspects of pregnancy loss was found to be the actual acknowledgement that the loss has taken place because parents were often confused and bewildered at the time (Mander 1994). Respondents spoke about feelings of despair, guilt, anger, self-blame and blame of others. Once the reality of the loss was accepted, parents then had to adjust to daily existence without the expected baby and make sense of a world that allowed such a tragic event to happen. The midwife/counsellors say that counselling can help parents deal with any unfamiliar thoughts and feelings and help them re-gain control of their life after the trauma of pregnancy loss, or indeed any event that has caused the patient to lose control. The major benefit of counselling, as opposed to many other therapies, is that it can produce results without the intervention of drugs.

Although counselling is fast becoming an integral part of our culture it is still a highly controversial subject and while counsellors and their clients celebrate the therapeutic potency of counselling, many social scientists and health professionals are not totally convinced of the efficacy of counselling and criticise it as '*a waste of time*' (Charlton 1999). They question how rigidly objective the assessing of its usefulness has been and suggest that perhaps it is naive to think it is the answer to a lot of problems when instead it could be the cause.

"Most of the women I've seen that have been having problems have been seeing a counsellor - maybe it's the counsellor that's caused the problems and not the other way round! (consultant/interview)"

More than 50% of professionals said that patients never request counselling without first being told that counselling is available.

Interviewer: "Do any of your patients ever ask you for counselling?"

Consultant: "I'm not sure that patients actually ask particularly for counselling because I'm not sure that they really are that well informed to know what counselling is."

Consultant: "I don't think they really do, no. I think it's normally shoved down their throat first so we tell them to be in contact with the midwives."

Several consultants made it clear they were not entirely convinced that counselling should be offered to bereaved patients yet more than 75% said they volunteer the services of a counsellor to patients in certain situations. This raises questions already broached by Cunningham (1999); has there been a rise in the numbers of counsellors because of a demand for counselling? Or do patients feel they should have counselling because more counsellors are available and counselling is offered to them?

The interviews with health professionals revealed that many are doubtful about the ethics of spending funds on a service, the results of which cannot be measured by audit. The response to the professional questionnaire was disappointing, with only forty-five replies, which indicates perhaps that the counselling service is a matter of low priority to them. Because most of the questionnaire respondents were midwives, with an average length of sixteen years service and an average age of forty-one, this part of the study was rendered almost ineffectual. The fact that those who did reply were older female members of staff meant the study had no input from younger health care workers or males who might have a different set of values concerning the importance of counselling as a part of patient management.

5:4 The Accessibility of the Counselling Service

Not too far into the study it was obvious that the availability of the counselling had not been consistent for all respondents. While 43% of the counselled group were offered counselling from a midwife/counsellor whilst they were still in hospital, none of the control group had seen a midwife/counsellor at any time during their hospital stay. One patient was not even aware the service was available. Fifty seven percent of respondents from the counselled group and 89% from the control group were either told about the service by hospital staff or were given the information leaflet and advised to ring one of

the numbers if they needed counselling. However, many respondents said they did not feel comfortable telephoning an absolute stranger to ask for counselling. Some patients said requesting counselling would make them feel inadequate or that it would be too much to re-live the experience again with someone who knew nothing about the circumstances of their loss.

"I know I would not have rang to ask for counselling. It was only because the community midwife was also a counsellor that I had counselling (respondent/counselled)."

"It made me feel a little bit weak, as if I needed some help. And I did feel as though, not beneath me to ring, but I felt as though only me needed counselling which is the wrong thing to think (respondent/counselled)."

"I would have felt uncomfortable. I don't think at the time I would have wanted to speak and go through it all again with somebody else. I would have felt as though I was putting myself through it again although I know they are there to pick up the threads (respondent/control)."

"Being told when you've had the baby, you should be made more aware. You get handed a lot of leaflets and you don't always think to sit down and read them' (respondent/control)."

Midwife/counsellors understand that it is difficult to ask for counselling from someone you have never met.

"I think it's very hard for ladies to be given a card, if you need a counsellor contact those names. They are faceless people, so I think it is more important that they actually see a face (midwife/counsellor)."

"No, they don't like ringing up. The people who have counselling and have it successfully get over the initial emotional loss, so they get over the funeral arrangements and the people who then go on to seek counselling are the people who recognised your face from the beginning and see that person as a helper (midwife/counsellor)."

Because there are several methods of referral of patients to midwife/counsellors, and none of them consistent, many patients might miss out on the opportunity of counselling when it is most needed. Midwife/counsellors believe it is the lack of referrals from various areas within the division that is partially to blame for the plans of the original counselling

service not coming to fruition. If the service is to be equally available to all patients then referrals to the midwife/counsellor should be systematic from all areas within the division, especially the Delivery Suite and the Day Unit.

Nevertheless, of all the hundreds of patients who lose babies every year only a small percentage of patients actually receive counselling. There were several reasons given by the control group as to why they did not have counselling. Some said that family and friends had supported them through their grief. Others said they had not been offered counselling or that they had not been given any information about the service, or if they were given information they felt unable, for various reasons, to approach the counsellor. Some respondents said that at the time of the loss they were not able to take in much of what was being said to them, therefore were not fully aware that counselling was available. As Mander (1994) suggests, at the time of the loss some parents are confused and are not really thinking clearly. In some instances control respondents did not want to be counselled by a person who reminded them of the loss, such as a midwife in uniform, or someone who was associated with the establishment where their loss took place.

5:5 Advantages and Disadvantages of Being Counsellled by a Midwife

Eighty three percent of interviewed professionals and 40% of professionals responding by questionnaire said there are definite advantages for patients to be counselled by a midwife following pregnancy loss. However, almost all professionals believe that although grounding in counselling skills should be given during midwifery basic training many point out that not all midwives should be midwife/counsellors. Rather they should use their counselling skills routinely in deliveries but enlist the help of more qualified midwife/counsellors for severely traumatised patients. Seventy-eight percent of the control group and 69% of counselled respondents also thought it was advantageous to be counselled by a midwife following pregnancy loss because of the midwife's medical background. Patients talked about needing to know what had happened to them and why they had lost their baby and the midwife was able to give patients answers to these questions.

"Because the counsellor was also a midwife she helped me get the results of the tests and explained everything, all the medical terms. Because she was a midwife I could ask her why? What could be the reason for it? This helped me a lot because

most of my questions were medical and she was able to help a great deal' (respondent/counselled)."

"The midwife helped me understand what had happened and answered my questions concerning the medical aspects (respondent/counselled)."

Of course the question then arises, if patients only need a midwife/counsellor to answer questions relating to the medical aspect of pregnancy loss, could not any medical person without counselling qualifications have answered the questions? According to a midwife/counsellor patients need counselling from a person who has both medical knowledge and counselling skills because sometimes the medical details of a loss are upsetting to patients. Although any medically qualified person could explain what has happened they would not necessarily have the skills to help patients come to terms with the emotional consequences. Because counselling is very much an on-going process and patients do not always think of questions at the initial counselling session, the benefit of having a midwife/counsellor present is that she can answer questions as they arise and help reduce any resulting trauma.

"Yes, she was brilliant. And I think because she sees pregnancies all the time as well, she was more in touch with pregnancies and everything and not just the medical side of things. She helped me through that, so I thought she had a good knowledge and her counselling skills were very good as well' (respondent/counselled)."

"I think it's more worthwhile for them to have it from a professional who is involved in obstetrics and midwifery. I think they have knowledge that they can apply to what the mother or the father is saying and sometimes can, not rationalise it for the patient, but can rationalise the statement themselves as a professional and see where that patient's coming from (midwife/counsellor)."

Nevertheless, although most respondents were in favour of being counselled by a midwife some believed there are disadvantages to this.

"The midwife can help sort out problems to do with the medical side of things but sometimes you would want to talk to someone else, especially if you thought they'd handled things badly at the hospital (respondent/counselled)."

"I felt that with her being a midwife she more or less banded with the doctors anyway, so she wouldn't even put your interests first. As a midwife, she sort of

like, sided with the doctors. They could do with being independent. I mean they could be trained midwives who no longer work at the hospital. That way they would have all the expertise but would be independent from the hospital (respondent/counselled)."

Forty three percent of respondents said they had benefited from the sessions, but commented that the midwife's uniform had upset them.

"It reminded me too much, cos I was in the hospital for a month and it was uniforms and doctors and nurses and I'd rather have had somebody entirely different (respondent/counselled)."

"I think it would have been better if she didn't (wear a uniform) because it reminds you of the hospital and what happened (respondent/counselled)."

"It upset me a bit! I mean that's what I was upset about when I came out of hospital as well, was the midwife's coming to see to me, walking in the door here and there was no baby when there should have been (respondent/counselled)."

These findings differ slightly from the opinion of a midwife/counsellor who believes that a uniform does not affect patients adversely and that patients actually prefer the counsellor in uniform because it gives them a sense of security. In this study the uniform affected 43% of respondents adversely and 57% percent thought the uniform was comforting or reassuring, or at least they were not deterred by it.

5:6 The Relationship of Patients with Medical Staff

Although some patients did form an affectionate bond with the counsellor/midwives it was obvious they did not have the same friendly relationship with other members of staff. Some respondents thought the counselling service was needed to counteract the attitude of medical staff who in their opinion had caused as much trauma as the pregnancy loss itself. Five respondents from each focus group said the lack of communication between medical staff and patients had caused problems.

"We saw three different people the day we came in, each was from different departments and there was a communication problem. One was saying we could do this, another was saying we couldn't and then they said we have got you booked in for tomorrow (focus group A)."

"My wife was rushed straight into hospital and there was no one to tell us what was going on. That was the worst part of it; everybody kept us in the dark. That is probably why we needed counselling, the run up to it and not knowing what was happening caused a lot of our grief (focus group B)."

It was also suggested by respondents that consultants themselves might benefit from training in counselling skills since they are often indifferent toward the patients needs and not very forthcoming with explanations for the loss. Yet according to a midwife/counsellor it is not only the counselling skills of consultants that should be developed but also the awareness of all concerned, which includes that of the patients.

"It is about educating patients that when they go to see a consultant, they are going for professional advice as an equal, they are not going as a subservient person. I think that patients have been more respected by consultants if they are able to engage in that way. That takes quite a big change for patients who see themselves as weak and subservient to go in front of an expert when in actual fact they have a need, and this person is going to provide some information for them to take away and decide what they want to do (midwife/counsellor)."

This ideal put forward by the midwife/counsellor, that consultants and patients should be on equal footing, is very noble but it is one that is not fostered by the majority of the medical profession. Doctors, and especially consultants, speak to women in medical terms, which might cause them to feel inferior since patients do not understand the linguistics of the medical profession (Symonds and Hunt 1996). Several respondents supported this theory and said they were not able to communicate with the consultants because they did not understand what was being said. Because of this they felt deliberately kept in the dark about the prognosis of their pregnancy.

5:7 When and How Should Counselling be Offered to Patients?

Many respondents, both patients and professionals, (70% control 75% counselled 54% professional questionnaire 58% professional interviews), believe it would be better if patients are offered counselling before they leave hospital. Patients thought to be given information about the counselling service by leaflet is not enough because the patient would have no idea of what to expect if they rang the counsellor when they got home. But if patients have already met the counsellor before leaving hospital it might be much easier for a patient to request counselling at a later date, since they would know whom they were contacting. In response to this a midwife/counsellor said that she had no

objections to seeing patients on Delivery Suite. In fact at times she had done this and the meeting usually progressed into ongoing counselling at a later stage. Unfortunately she is not always informed of losses as they occur so it is not always possible to visit patients before they leave hospital.

In the case of miscarriage or stillbirth some patients thought it would be more beneficial to have a counsellor available to help them through the actual event or as soon as possible afterward. However, others said they were not thinking straight at first and needed time to get used to what had happened.

"I think maybe if they approached – maybe not on the actual day perhaps but within a couple of days. I mean times makes things easier, but you are so traumatised at the time of it happening, especially stillbirth, you are not thinking straight. I had a guilty conscience for the first couple of days, I felt as though it was my fault and I was apologising to people because things went wrong. After I'd had my baby I said to my husband I'm so sorry and he went what are you apologising to me for? It's not your fault, but you feel guilty and after a couple of days once things start sinking in of what's really happened, the reality starts setting in, and you start to think a little bit more logically about the situation. Yes, I think you should be asked, but not immediately after – in a couple of days or weeks (respondent/counselled)."

In accordance with Kohner & Henley (1991) for many women it was not until a few months after their loss that they felt they needed counselling.

"I think at the time it might have been too much maybe yeah, yeah. It just seemed too much all of a sudden. I think I needed a bit of space and then I felt I needed counselling a bit later on. Things were just up in the air at the beginning. It was..... things that were going through my mind, I maybes wasn't seeing straight and I think I needed time to get things sorted in myself and then I could ask the questions and let someone tell me how I should be feeling. If what I was feeling was right or wrong (respondent/control)."

Respondents at the focus group meetings spoke of their despair when they returned home if they had not seen a counsellor before leaving the hospital.

"I went home – and I felt I'd been dumped basically. It was a horrible feeling. You know I'd been in hospital all weekend and then on the Monday that was it, you went home without this baby. It was horrible. There was nobody, it

was just like 'go home' that was it. There was nobody coming to see you, nobody to talk to and that was it (focus group A)."

Of course some parents are not aware that they need counselling until months or even years after the loss (Kohner & Henley 1991). There are many reasons why bereaved parents do not request or receive counselling at the time of their loss. Parents may feel they do not need counselling or they may not have been offered it. Others, having close family and friends to support them through the grieving process, have no need for the assistance of a counsellor. There is also the possibility that the word 'counselling' might be 'off putting' to some people who may not want to be associated with an activity that would make them appear weak minded. For some, the bereavement will have called into question other life issues such as, relationships, job, religion, or childhood experiences. Although counselling can help them toward making the adjustments needed to put their life back on course a bereavement counsellor might not be the most suitable candidate to help them deal with these problems (Hindmarsh 1993). With issues arising from bereavement, but not connected to it, a patient might gain more benefit from the expertise of an independent therapist.

Parents described their distress when they were told their baby was dead before the birth. In most cases patients still had to go through the labour to deliver the baby, knowing there would be nothing to show for it in the end (Kohn and Moffitt 1994).

"My baby was a stillborn baby and I knew 24 hours before that my baby had died in the womb and I think the counselling should start then, at that point. It was more than 24 hours – and I was just shut in a room. I felt like a zombie, I thought I was away with the cuckoos. Everyone left me. I was obviously in shock. I suppose my family were drifting in and out, but I think I needed counselling then (focus group A)."

"We lost our baby last year, he was stillborn, and he'd stopped moving and we came through to the hospital on the Friday and I had a scan and the baby had died. We were told that we could take as long as we wanted to come in and go through all the labour and everything, but the next thing was that we were being told that I had to come in the next day and that was all I knew. There was nobody to talk through it with us, or it was just like, come in, you'll be induced and that's it. I think that there should be some sort of counselling service there because I was just in total shock, and I just wanted to get out of hospital (focus group A)."

When a baby dies in the womb patients are given a choice of either the surgical or medical procedure to bring the pregnancy to an end but often patients did not understand the implications of these options. The following is an excerpt from an interview with an Asian respondent:

Respondent: "If I went for the operation I wouldn't mind, because then I wouldn't know, but because I took them tablets, that tablet showed me the same labour pains the backache everything and when I was seeing blood clots and that made me more upset when I was in that delivery room, the signs of blood clots. I was really in tears. But the nurse wasn't there, I was on me own."

Interviewer: "Would it have been better if a counsellor had been with you when they told you that you were going to lose the baby?"

Respondent: "Yeah, I think it would have been much better. Because when I went into hospital the nurses said that with the operation there's side effects, vomiting and all that lot and its better to take the tablets, it's easier. I thought they know it all so it must be right, that's why I went for the tablets, but if I knew what I was going to go through, I wouldn't have gone for the tablets, I'd have rather had the operation."

Interviewer: "So taking the tablets caused you a lot of upset?"

Respondent: "Well, I think that was the worse thing, because it was the same pain, like labour but at the end of it I had nothing to show for it. All I showed was the blood, that's all I could remember. Well it's really the tablets isn't it? They ought to have explained it in more detail."

It appears that a great deal of upset experienced by patients was the result of not being aware of what to expect and not understanding the choices available to them. Many patients felt they were kept in the dark about their condition, especially those who were advised to terminate the pregnancy because of foetal abnormality. Some believed they would have felt more contented if they could have considered their options, together with a counsellor, before making their final decision of whether or not to go ahead with the termination. As it was patients were ill prepared for not only the medical aspects of the termination but also the substantial anguish that was to follow. These aspects of pregnancy loss are considered in the next chapter.

Chapter Six

Counselling as an Aid to Understanding Available Choices

6:1 The Need for Counselling Before and After Termination for Foetal Abnormality

Patients diagnosed with foetal abnormality suggest that counselling should be available at the time of diagnosis so that the counsellor can explain their options. "You need to see a counsellor at the very onset when you are diagnosed as having a foetal abnormality and things might be different. You might understand more about what's going on (counselled respondent)." The midwife/counsellors agree it is better if the counsellor is actually with the patient at the time the bad news is received.

"When women are diagnosed with foetal abnormality, this is the time when a trained counsellor should be present. They are given the drug *mifepristone* to deliver the baby. It's very traumatic for women when the baby is dead but can be even worse if the baby is still living. In these cases the onus shifts to them whereas if they were given a surgical induction the onus lies with the medical staff. When women see the products of conception that looks like a baby and they are often left with the thought "oh I've killed my baby." In social terms they see a normal baby and think they've killed the child by taking the tablet. Patients need to be prepared for what they are going to see, especially when they are more than twenty weeks gestation. Well eighteen weeks really."

Three respondents from each of the focus groups also believe that a counsellor should be present at the time of diagnosis because parents have to make a decision about whether or not to terminate the pregnancy, a decision that does not come lightly (Furedi 1999). Some respondents believe they were rushed into making the decision to have the termination.

"I was going to write a letter to the consultant or somebody because I think – and my partner agrees, that we were rushed into it. But then it stayed with me – it wasn't something that I could go on to another stage, because it stayed with me. I think we were, not pushed, but rushed into it (respondent/counselled)."

"I think you should be given the choice so you know whether to go ahead with the termination, what choices you have, and what sort of counselling. What if you do terminate, what will you get after that if you decide not to terminate, what there is there for you. But definitely straight away, because we felt we were rushed into the decision, you know we were told on one night, and the next night they said 'oh

we've booked you in' and that was the end of it. There was nothing at all. We just think that they know best, so we went along with them really (focus group B)."

Choosing between life and death is a heavy responsibility for anyone and it is even more difficult if parents have a conflict of beliefs and life values (Anspach 1997). The decision to terminate a pregnancy can lead to tribulation within a family, eventually splitting the family up if parents cannot reach an understanding. Feelings of guilt are compounded with a sense of imperfection, either of the self or their partner, and in some instances recriminations from one partner to the other put an immense strain upon the relationship. Even without these added pressures parents who choose termination for foetal abnormality are not always prepared for the long term shock and devastation that often follows their decision (Stewart & Dent 1994). Although the numbing effect of what is happening around them will carry parents through the actual termination, it is afterwards, when the gravity of the circumstance is realised, that some parents find most difficult to cope with. Many parents feel sure they have made the right decision by choosing to end the pregnancy rather than bringing a disabled child into the world to endure the stigma and hardships that family and child would be sure to face in our society. Other parents feel they have to justify their decision to the rest of the world by declaring that "the pregnancy was not meant to be" or "aborting the unborn child is helping nature take its course", and often imply a portentous or pre-ordained quality to the event (Kohn & Moffitt 1994).

Since the advances of medical technology with genetic testing and antenatal diagnosis parents have a greater degree of freedom in choosing whether or not to abort a foetus they know has a defective disorder, but this too puts an added burden on parents. According to ARC, Antenatal Results and Choices, around 700,000 pregnant women each year are offered some form of prenatal testing and although there is a risk that their baby will have an abnormality 35,000 women choose to go ahead with the test. For most women the test results show a normal pregnancy but for some the news that their baby has a serious disorder may be devastating (ARC). Furedi (1999) says that though there is no suggestion women are forced or even encouraged to take antenatal tests, if the tests reveal abnormalities the choice to terminate a pregnancy sits firmly on the parent's shoulders.

Often parents have to wait some time after receiving a diagnosis of foetal abnormality before the procedure to terminate is initiated. Unfortunately in some medical institutions parents do not have access to someone who can explain the possible consequences of their decision. This waiting period can be agonising, especially if parents know the baby is still alive in the womb (Furedi 1999). Parents then have to face the ordeal of delivering the baby and depending on how far the pregnancy is advanced will be given the option of either the surgical or medical procedure to terminate the pregnancy. Although the process of termination may differ slightly in various hospitals throughout the country, generally they follow a similar course of events. The surgical procedure, which may involve aspiration or D&C under anaesthetic, is usually only performed for first trimester terminations. With second trimester terminations patients are often advised to opt for the medical procedure to reduce any risks to the mother that could arise from the anaesthetic given with the surgical termination. With the medical procedure a drug is administered, usually by tablet or pessary, to induce labour. Labour can last for several hours before the baby is delivered and the pain might be even more excruciating because women labour in vain. But as Kohn & Moffitt (1994) point out, with any procedure the end result is the same, a dead baby!

Stewart and Dent (1994) state that while there is no evidence to suggest a significant difference between the responses of women who lose babies through miscarriage or stillbirth, a considerable difference has been found between these and cases of termination for foetal abnormality. The extent of the grief that results from a termination for foetal abnormality was confirmed by a retrospective study by Lawrence (1989; in Stewart & Dent 1994). Seventy-five percent of the forty-eight mothers taking part in the study experienced an acute grief reaction that was sufficiently severe in twenty-one percent for them to need psychiatric help (Mander 1994). These mothers felt that the actual decision to terminate their pregnancy had aggravated their grief. A similar study by Iles (1989 in Stewart & Dent 1994) showed that in the first of three semi-structured interviews with mothers who had undergone termination for foetal abnormality, thirty-nine percent were identified as 'psychiatric cases' although in subsequent interviews the number decreased. It was also found that the psychiatric outcome is worse if the abnormality was non-life threatening, such as with Down's syndrome or achondroplasia (Mander 1994; Furedi 1999).

In a similar study carried out by Whitevanmourik, Conner, & Ferguson-Smith (1999) to investigate the psychosocial sequelae of a second-trimester termination of pregnancy (TOP) for foetal abnormality, the researchers found comparable results.

"After appropriate consent was obtained, 84 women and 68 spouses were visited 2 years after the event and asked to complete an extensive questionnaire. Most couples reported a state of emotional turmoil after the TOP. There were differences in the way couples coped with this confusion of feelings. After 2 years about 20 per cent of the women still complained of regular bouts of crying, sadness, and irritability (Whitevanmourik, Conner, & Ferguson-Smith 1991)."

Although all counselled respondents who had undergone termination for abnormality believed they had benefited in some way from counselling, all suggested that counselling should be available at the time of diagnosis to help them understand their options. Respondents spoke of being rushed into the termination and having no one to explain how the termination would be carried out or what would be the consequences if they decided not to terminate. Others said they were unable to move on from the experience.

"But then it stayed with me – it wasn't something that I could go on to another stage, because it stayed with me (respondent/counselled)."

The reactions to loss and the consequential grief of those respondents who elected to have an abortion differ from those whose pregnancy ended by miscarriage or stillbirth. Although all respondents suffered guilt or self-blame to some extent these emotions were more pronounced and lasted longer in those who had elected to terminate the pregnancy. This might be expected since termination respondents had the added psychological burden of the decision to end a life, even though in some incidences the baby was not expected to survive anyway. Because of this it was decided to invite only respondents who had suffered miscarriage or stillbirth to one focus group meeting and respondents who had elected termination to another, since both sets of respondents had different agendas to address.

6:2 Counselling, Pregnancy Loss and Relationships

Several respondents said that their partnership had gone through a difficult period after the pregnancy had failed and some couples had split up. According to SANDS (1999)

these problems can be re-occurring for several years after a miscarriage or stillbirth, sometimes until the 'era' for pregnancy and childbirth is over for the couple.

"At one point we were fighting a lot and arguing and like it was nice for the midwife to say, well it's normal. She said that we were both bereaved but your husband has seen you so ill so he's sort of gone through another part of it that you hadn't gone through even though you were the one poorly on the bed (counselled respondent)."

....."We split up afterwards, basically he was like on a level until that happened and he just went to pot (counselled respondent)."

"I think she saved our marriage really. We were just really in a bad way weren't we? (speaking to her partner) You know she made me understand him, and visa versa. The more time was going on the worse things were getting between us and the lack of communication and there was hurt as well, we definitely needed a third party. I dread to think what would have happened to the marriage really (counselled respondent)."

Anspach (1997) maintains it is the feelings of guilt and the sense of imperfection, either of the self or their partner, and recriminations from one partner to the other that can put an immense strain upon the relationship.

".....all sorts of feelings I blamed him for it. Everything (Counselled respondent)."

According to Whitevanmourik, Conner, & Ferguson-Smith (1999) husbands reported increased listlessness, loss of concentration, and irritability for up to 12 months after a TOP. In the same period there was increased marital disharmony in which 12 per cent of the couples separated for a while and one couple obtained a divorce. The authors suggest that these problems could be attributed to a lack of synchrony in the grieving process.

Nevertheless, some respondents reported that since the loss their relationship had actually improved.

"The thing is... it might have had an effect on us. To be honest I don't really think it has, if anything I think it has brought us closer. Yeah, I think it's brought us really really close, it hasn't pushed us away. We've met people

when we've been to the cemetery who have split up through losing a baby but it didn't happen to us two, thank God (counselled respondent)."

Kluger-Bell (1999) says the lack of attention paid to men's emotional reactions in matters related to childbirth has led to the conclusion that pregnancy loss does not affect men. However, it has been found that many men are deeply connected to their pregnant partners, often referred to as psychic gestation, but in western culture a father's role is seen as beginning at birth rather than at conception. But Mirowsky and Ross (1995) state that men and women differ in the nature of their emotional response to trauma. While women get sad and depressed, men get angry and hostile in an attempt to hide their true emotions. This is because men are socialised for competitive and combative roles that allow and even encourage the outer expression of anger and hostility, whereas women are socialised for nurturing and supportive roles that discourage such expressions. In Mirowsky and Ross' opinion women have higher levels of depression and men higher levels of anger and people with higher levels of anger have lower levels of depression and therefore less stress. This tenet is perhaps not entirely true in pregnancy loss, if indeed it is with any catastrophic event.

"So five years on I'm still full of anger. I need to get it off me chest. I've got psoriasis through it now. I'm still full of anger (Male respondent)."

"I need to bring it out. I want to talk about it freely because I was so proud, it was me first son. Nothing in this world can replace him. But it was the first time I'd ever had a boy, I'd had two girls before and I was so proud. But it was just like the anger at the time, and I still need to get rid of it (Male respondent)."

6:3 Counselling Ethnic Minorities

During the study only two patients coming from ethnic minority backgrounds volunteered to be interviewed, one from of the counselled group and one from the control group. When asked why she thought so few Asian women request counselling following pregnancy loss the counselled respondent replied that people from ethnic minorities might not understand what counselling is about and how it can help, which was suggested by Rawson (1999). Although this particular respondent had the support of her family and husband she needed to talk to someone about the ordeal she had endured while being induced to bring about the birth of the dead foetus. This had caused her a great deal of

trauma and she wanted reassurance from the counsellor that she had not been used as a 'guinea pig' when she was given tablets to bring on labour.

The control group respondent said she did not speak English therefore her husband replied to the interview questions. He believed one of the reasons his wife had not needed counselling after their baby was stillborn is because his family was there to support her.

Interviewer: "Were you aware that counselling was available from the hospital midwives?"

Husband: "Yes, the bereavement support worker told us. She said if we had any problems, you know. But we have a big family. There's my mother, father, brothers sisters that was the way things were, you know. But they were very supportive with us at the hospital. I must give credit to the nurses and what have you. They were brilliant all the way along."

Interviewer: "Did you decide you did not want counselling?" [referring to wife]

Wife: "Well I don't speak good English you know so I..."
[these were the only words the woman spoke throughout the entire interview]

Husband: [breaking into the conversation and talking to his wife in Urdu]
"Yeah she did."

Interviewer: "Did the family help you through this?" [referring to the wife]

Husband: "Yeah, my mother stayed here for a while and all the uncles, aunties, when she came home. Obviously she did go to the funeral, but we got the job done quickly. We said to the bereavement support worker, look here in our culture if somebody dies we expect to get them buried quickly even back in our native country, we expect it to be buried as soon as possible."

Interviewer: "Are you Muslim?"

Husband: "Yeah. So we said to the bereavement support worker, once you sort your side out like, could you get the funeral done as quickly as possible. So she got it done very quickly."

Corey (1996) discusses the family dynamics of Asian populations and explains how individuals, being subject to collective solidarity of the family, might not perceive a need for counselling. The Asian respondent praised all hospital staff for their care and efficiency, especially the Care and Support worker who was very understanding and had helped arrange the burial as soon after the death as possible, which is in accordance with traditional Muslim custom. At which point he added that his wife had not needed counselling because “if God's going to give you something, he's going to give it to you. If he's going to take something off you, he's going to take it.” Counselling could not change the will of God for this respondent!

6:4 Better Outcomes For Patients

The positive outcome to the counselling sessions depended on who had brought the sessions to a conclusion. It is evident that patients who brought the counselling sessions to an end themselves were more satisfied with the counselling they had received. Sixty two percent of counselled respondents said they had no need for further counselling after they themselves had brought the sessions to an end. However, twenty five percent said that counselling was brought to an end before they were ready and in all of these cases it was the counsellor and not the patient who had suggested the counselling should cease.

“She just said, “are you alright now”. I said I was but there’s still a lot of things going on, I seem to be getting better but then when it came round to when it was due, and various things like that, it started all over again (respondent/counselled).”

According to the midwives, counselling sessions can be carried on for as long as a patient feels is necessary, which is usually anywhere between one and twelve weeks, and sometimes longer depending upon the severity of the grief. The frequency of appointments is usually by agreement between the patient and the counsellor although it was remarked upon at focus group meetings that some patients were seen on a daily or weekly basis while others only once a fortnight, which they thought was not enough. A male respondent suggested that if a set amount of sessions were agreed at the commencement of the counselling, patients would know when they were expected to come to a halt. However, realistically it would not be known by the counsellor at the beginning of the sessions how traumatised the patient was and subsequently the number of sessions they would require. Some patients who originally thought that the period of

time they received counselling was long enough had since seen an independent counsellor. This shows that even when patients bring the counselling sessions to an end themselves they might still be suffering from some unresolved grief that will surface in the future.

Nevertheless Kohner and Henley (1991) point out that not all people can be helped to overcome grief with counselling but it will provide them with the chance to talk about their circumstances and perhaps understand their feelings better. All respondents who thought they were still in need of counselling were given the opportunity at the time of their interview to resume the counselling sessions with the midwife. Patients were also informed that they could contact the midwife/counsellor at any time in the future if they wanted the visits to resume.

6:5 The Availability of Counselling at Other Hospitals

The counselling service offered by the midwives at South Cleveland appears to be unique in its scope, certainly in the North East of England. Most other hospitals in the area, such as the Royal Victoria Infirmary, Newcastle, Dryburn Hospital, Durham and the Memorial Hospital, Darlington, have no facility for the counselling of patients in the same way as South Cleveland Hospital. The Royal Victoria Infirmary has a large maternity unit and accommodates many patients with complicated pregnancy but relies on the services of a consultant to counsel patients. The midwives at Dryburn Hospital attend a bereavement group that is run mainly by the patients themselves. Midwives keep a low profile in the proceedings and never wear a uniform at meetings because they think it can be disturbing for some patients. Darlington Memorial Hospital has no facilities at all for counselling bereaved parents. Looking further afield, the community midwives of The Royal Alexander Hospital, Paisley, do counsel patients but usually during post-natal visits. They offer more practical assistance, described by Murgatroyd (1996) as the prescriptive or directive style of counselling where the counsellor guides the client toward an appropriate action. At the Royal Infirmary, Leeds, which also has a large maternity unit, a midwife is working toward setting up a similar service to the one at South Cleveland because she believes that this is the way forward for patients who are coping with the trauma of pregnancy loss. However, because of the lack of funds and qualified midwife/counsellors at this time, the service is still in its infancy.

The only hospital contacted during the research that has a counselling service comparable to that at South Cleveland is Guy's Hospital in London, which also has a midwife/counsellor working with patients and their families. The midwife/counsellor, who is engaged full time in this role, explained that at Guy's there is a very high birth rate, around 6,000 a year, but there is also high foetal mortality because like Teesside they serve a socially deprived area. Every patient who experiences a miscarriage or stillbirth at Guy's is visited by the midwife/counsellor before leaving the hospital. Patients diagnosed with foetal abnormality are seen by the counsellor either at diagnosis or as soon after as possible. She believes her role as a midwife/counsellor has become even more important with the development of new technologies in obstetrics. Because abnormalities are now more easily detected more patients are faced with the choice of termination and counselling is needed to help them make this decision, and to help them cope with any resulting trauma. Often the midwife/counsellor is present to support both the patient and the delivery staff during terminations for foetal abnormality, since the staff can also be profoundly affected by the procedure of termination. Not only is there the anxious episode of inducing labour by medical means when a patient is diagnosed with foetal abnormality, but now, with the aid of the ultra sound scan, a termination can be performed by injecting potassium into the heart of the foetus. This causes the foetus to 'macerate', which can be quite alarming to both parents and staff, and therefore all concerned need support. At Guy's, as at South Cleveland, it is believed that the way forward in normalising pregnancy loss is to raise the awareness of consultants, midwives, health visitors, general practitioners, patients as well as society at large. These issues are also fundamental to the work of 'Antenatal Results and Choices' (ARC) a national group that support parents who choose termination for foetal abnormality.

6:6 The Anticipated Long-Term Effects of Counselling

It is difficult to assess the long-term effect of the counselling service, especially when no follow up interviews could be carried out with the respondents. This is because the ethics committee at South Cleveland Hospital believe it is not advisable for patients to be subjected to on going interviews that might constantly remind them of their loss, thereby prolonging their grief. Ideally, respondents should be contacted after the initial interview so that progress can be monitored closely. In any future study respondents could be

recruited from the general public and so would not be under the jurisdiction of the hospital, consequently it would be their own personal choice as to whether or not they chose to be interviewed on an on going basis. Then again the hospital's concern about the well being of patients is quite understandable because many respondents found it very upsetting to re-live their experience, even though they thought they had put the experience behind them and moved on in life.

Some respondents had become pregnant again, although the outcome of a subsequent pregnancy has not always been fruitful. In most instances women who did become pregnant after a failed pregnancy re-lived the events of the failed pregnancy and always expect the worst to happen. However, it is reported that even if subsequent pregnancies do fail parents are more able to cope because of the understanding they gained from the counselling they had previously received. Similar to the study carried out by Worden (1989) respondents of this study reported that counselling had helped to diminish the aftermath of grief and helped them cope better with subsequent losses. But midwife/counsellors believe it is too soon to estimate the long-term effects of counselling because the true value both therapeutically and financially might not be revealed for at least five to eight years, although testimonials from patients suggest that counselling for some people can have lasting long-term effects.

"I think when you've experienced it, and seen the benefits that it's done for you, the benefits that it did for our marriage and coming to terms with the loss, and working through that and just moving forward, really because we were just so, you know (respondent/counselled)."

"I do think if I hadn't had the counselling I don't think I would have gone on as forward, because I'd have been holding things back more. You are better getting them out of your system. I think people are much better with you, if you cry and have all this carry on in the first six months after you've lost the baby than wait six years then suddenly go bananas (respondent/counselled)."

However, 58% of professionals believe the long-term effects of counselling could be detrimental to patients especially if they become dependent on the counsellor or if a patient, after being counselled, is still suffering emotionally because this might cause them to feel even more inadequate. They agree with Charlton (1999) that counselling could be detrimental if people are lulled into thinking that because it is popular then 'it

must be a good thing' and warn against putting too much faith into something that as yet has no proven therapeutic effect.

Nevertheless, there is some evidence to suggest that bereavement support group intervention can have a positive effect on grief. In a study carried out in the USA with HIV-1 positive homosexual men who had lost a close friend or intimate partner it was found that bereavement support group interventions may prove to be a primary therapy for psychological distress after bereavement. The support group was also found to be an adjunctive therapy for sustained control of plasma viral load in conjunction with highly active antiretroviral therapy (Goodkin et al 2001:44). Following bereavement the level of corticotrophin-releasing hormone (CRH) increases in the body but with regular group therapy over a twelve-week period it was found that the level of CRH decreased and was maintained at 6 months follow-up. Of course, these results may be peculiar to HIV sufferers and as yet no tests have been done with non-HIV bereaved patients. Also the tests were carried out within a support group and not in a one to one counsellor/client setting. Similar investigations in the future could be carried out to ascertain if CRH levels have a comparable reaction in clients who undertake bereavement counselling to those who have group therapy.

6:7 The Evaluation of the Counselling Service

Since counselling is extremely difficult to define, being an abstract conception without physical substance, as discussed by Davis & Fallowfield (1994:23), the usefulness of the counselling service at South Cleveland can only be measured by its subjective effect. This is said by counsellors and counselled respondents to be significant in bringing control and purpose back into the lives of traumatised patients following pregnancy loss. Most patients who received counselling from a midwife/counsellor believed their grief was lessened because of the care and support the counsellor gave them, although many criticised the accessibility of the service. Even though the service has had positive results it is obvious that not all respondents had the same level of access to the service and many patients could have missed out on the opportunity of counselling because of the haphazard referral methods. To ensure that patients do not miss out on counselling, respondents recommend that midwife/counsellors make themselves known to patients as soon as possible after a miscarriage or stillbirth takes place. If a patient has already met

the counsellor before leaving hospital, and they need counselling at some later date, patients would have more confidence to telephone for an appointment.

Respondents thought that information leaflets might also be useful to explain what counselling is about and how it might help patients understand and normalise what has happened. Because Teesside has a multi-ethnic population, who as yet have taken little advantage of the counselling service, it might be advisable if all medical staff are given specific training in the cultural traditions of ethnic minority patients, in accordance with Rawson (1999). Many of these patients do not read English so information leaflets should be translated into other languages so that patients from ethnic minorities are more aware of the support that is available to them.

Respondents made various suggestions as to whom should make first contact, the patient or the counsellor, and at what point in the proceedings the patient should be offered counselling. Most respondents are in agreement that the offer of counselling should come from the counsellor either at the time of diagnosis in cases of foetal abnormality or when a patient is told the baby has died in the womb. With miscarriage and stillbirth it was suggested that the counsellor should introduce herself to the patient before the patient leaves hospital. If the patient decides against counselling at that point she could contact the counsellor at a later date if she feels the need to do so.

Respondents who were diagnosed with foetal abnormality believe a counsellor should be present with the patient at the time of diagnosis to explain the options available and their consequences. Medical details of the abnormality should be rationalised for patients and perhaps backed up with literature that patients could take home to digest. Once the options have been fully understood and talked over with a counsellor, if the patient decides on termination they would be more aware of the possible effects of the various methods of labour induction. This same advice and support should be available to patients in cases where the foetus has died in the womb. If patients are more aware of their medical predicament they would be more self-assured when speaking with consultants and other medical staff, which is how midwife/counsellors envisage patients should be. Fathers too should be given more opportunity of counselling and encouraged

to record their feelings for other bereaved fathers to read so that they might feel less self-conscious about expressing grief.

Recommendations put forward by health professionals were mostly subject to the financial viability of the service. Although the cost effectiveness of the service has not yet been established the midwife/counsellors believe that one of the benefits for the Trust from counselling might be the money saved in litigation but this will not be known until a few years hence, if at all. However, most professionals agree that some form of counselling service should be available to patients in the event of pregnancy loss but some consider that to offer a complete service to patients, where a counsellor sees every patient at the time of loss, would require more than one midwife. The ideal number of midwives needed for this service would be three to ensure that a midwife/counsellor would be available in the hospital at all times. The counselling service at Guy's Hospital in London works well with only one midwife/counsellor working full time in this capacity, visiting women at the time of their loss and supporting staff and patients at terminations. But to adopt this level of operation might in some ways be seen as a step backward for the service at South Cleveland Hospital since patients on Teesside presently have the benefit of counselling in their own homes. Nevertheless, if patients are seen by the midwife/counsellor at the time of diagnosis or loss then it could alleviate some of the stress that patients experience merely because they do not understand what is happening to them, resulting in fewer patients needing counselling at home.

But offering counselling to all patients routinely while they are still in hospital also has its disadvantages and some consultants are concerned that patients might receive counselling just for the sake of it. They propose it might be more advantageous if the midwife/counsellor talks to patients at the time of loss but leaves it up to the patient to make an appointment with the midwife, if and when they need counselling. Other consultants suggest the way forward is to only offer counselling to patients after their routine post natal appointment, six weeks after the loss. However, midwife/counsellors say this shows little understanding of the nature of grief that accompanies pregnancy loss since for many patients it is at the time of loss, or even before, that counselling can be most helpful. Health professionals themselves may need to take advantage of the counselling service, especially if they are involved with the delivery of stillborn or

severely macerated babies, which might become more prevalent as technology in obstetrics extends to the Northeast of England.

The counselling service presently offered by South Cleveland Hospital has produced good results for the outcome of patients' treatment following pregnancy loss, according to counselled respondents. The service is very much at the cutting edge of health care in the North of England and is admired by other hospitals who themselves are working toward such a service, because they believe that counselling is a way forward in helping patients who suffer trauma following pregnancy loss. Although the counselling service does not operate at optimum potential it is the forerunner of an aid that is increasingly in demand in all areas of medicine. Many professionals may be of the opinion that at best counselling is a waste of resources but if other contemporary medical institutions believe that counselling is the therapy of the new millennium, then this vote of confidence cannot be ignored. One question that might be contemplated when considering the essentiality of counselling in pregnancy loss is, if it is deemed necessary by the *Human Fertilization and Embryo Authority*, a body of respected medical professionals, that parents who cannot conceive a baby without assistance should be counselled, then how much more essential might counselling be for those who have already conceived and have lost their baby?

Although the reason for including interviews with a control group was to ascertain how these respondents had managed to overcome grief without counselling, it was found that half of control group respondents were of the opinion that they may have benefited from counselling if they had known it was available. This implies that these respondents believe that counselling is beneficial for the resolution of grief. However, if respondents from the control group had volunteered to attend a focus group meeting it might have been better established in what way they thought counselling could have helped them. Nevertheless, the interviews with the control group respondents did identify the importance of a midwife/counsellor introducing themselves to all patients who suffer pregnancy loss, since none of the control respondents had seen a counsellor before leaving hospital. In view of the fact that many respondents said they would find it difficult to ask someone they had never met for counselling, it perhaps explains why control group respondents did not have counselling and why 56% of them thought that the hospital could do more to help bereaved parents.

There was no evidence to suggest that control group respondents were any less recovered from the trauma than the counselled group, although there were one or two patients from each group of respondents who clearly had not come to terms with the crisis. Whether counselling could have helped the control group respondents resolve their grief remains to be seen since those respondents from the counselled group with unresolved grief had in some instances seen several counsellors and were still making little headway in resolving their grief.

Perhaps the fact that a few respondents were not able to overcome grief, even with the help of a counsellor, indicates that some people find it more difficult, for one reason or another, to put past events behind them and move on in life. The inability that some people have to recover from a traumatic event, that only a few decades ago would have been regarded as a run of the mill experience, might be due to the encouragement we are given today to externalise our emotions by talking about them. The case might be that in talking about our emotions we keep them fresh and alive in our mind, which might only prolong the agony, but as Becker (1997) points out it is by constantly drawing attention to unacceptable situations that eventually brings about social change. Only a few years ago it was not considered fitting to wash one's dirty laundry in public, since society was averse to public displays of emotion. Today we are deemed to be psychologically unsound if we do not verbalise emotional reactions in certain situations. Thus what is socially acceptable behaviour in one decade can change dramatically in the next, as is illustrated in chapter seven.

Chapter Seven

Reality and Representation in Post-Modern Times

7:1 Changing Face of Society and Emotion

The embodied experience of women in pregnancy and pregnancy loss has been an ever-changing issue in western society, but at the present time some women are not able to come to terms with that which appeared, at one time, to be an accepted part of every day life. However, even though women in the past were not allowed to openly express emotions concerning failed pregnancy it is evident that they were emotionally affected by a loss in some way, which is witnessed by testimonials of women who lost babies thirty years ago. But what is also borne out by these statements is that women were given no emotional support at all after the event, they just had to 'get on with it'.

"I've had a stillbirth and I've had 4 miscarriages and they are all like similar.....Them days you just got took in hospital, got your tubes cleaned and they sent you home..... We just had to get on with it. I mean that was 31 year ago, I mean you just had to get on with it (mother of counselled respondent/focus group A)."

This raises the question, what is different about the emotional experience of losing a baby today than it was thirty years ago that necessitates that some women need counselling? According to Harré (1986; 220) the reason is that the components of emotion; 'vocabularies and socially recognised displays'; 'what are taken to be emotionally significant or salient bodily states'; 'an ontology of relevant objects, people states and happenings'; and 'the local moral order', do not remain historically constant. Subsequently, women of today might view their experience of pregnancy loss in a totally different way from their mothers' and grandmothers' generation. Whereas older generations of women had suffered a *silent sorrow*, alienated from society (Kohn & Moffit 1994), in fear that they might be accused of 'doing something' to have caused the pregnancy to abort, women of today demand that society listens to their stories of suffering which they feel will allow them to properly grieve their loss. The experiences of women in pregnancy related issues are coloured by their embodied experience of changing social paradigms.

According to Becker (1997;130) these feelings of alienation of self from society in the West are because people have a firm conviction that individuals create all bodily experiences themselves. This image fosters 'body/self alienation' when their myth of personal control of their body is shattered by the onset of physical anomaly. This belief, where the body is seen as a projection of the self rather than of the collective, can serve as an 'entrapment of the body' and sets in motion a struggle to regain control, which in turn estranges them even further from society. Becker contrasts the embodied experience of westerners with that of the Fijian self, where the locus of personal identity resides in relationships and bodies that are, to a degree, undifferentiated from the rest of their society. The aetiology of a physical symptom is regarded as being a transgression perpetrated by the whole of society, and not just the responsibility of an individual, thereby confirming the inseparability of the self from the collective. This is a similar view to Asian Indian populations where the individual ego is subject to collective solidarity (Rawson 1999).

Symonds & Hunt (1996) say the change to the mechanistic view of the body in the West has reduced the experience of childbirth "to a series of components on a production line" and has made matters worse for patients (ibid.). When a pregnancy does not go according to plan, medics use metaphors such as dysfunctional labour, uterine inertia, and uncoordinated uterine action to describe the medical condition of women. But these terms usually intensify a woman's thoughts that her body is not behaving according to the medical model and is therefore stigmatised as abnormal or unacceptable to self and society. Women do not often speak of the distress they feel upon discovering their body is dysfunctional, inert and uncoordinated. These feelings are embodied in the woman and continue to influence without her knowing (Kluger-Bell 1999). Issues discussed by Symonds & Hunt and Kluger-Bell, concerning communication difficulties between medical professionals and patients, were raised in the study by women who believed they were deliberately kept 'in the dark' by medical professionals and in some instances were encouraged to believe it was their own fault that a pregnancy had not come to fruition.

The body has been the subject of much debate and is implicated in many cultural studies by anthropologists, which Csordas (1994) argues has 'problematized' our understanding of the body. However, he arrives at the conclusion that "if there is an essential

characteristic of embodiment, it is its indeterminacy," especially when post-modern theorists contend the legitimacy of the body and question whether or not there is any such thing. Habermas (1987:5) states that in post-modern times imagination has taken precedent over logical reasoning to such an extent that it is difficult to comprehend the essence of late-modern practices, although many social scientists (Lash & Urry 1987; Giddens 1991; Heelas 1996), suggest it is about the transgression of boundaries between reality and representation. However, it could also be argued that this is true of all cultures in any historical setting.

The various works cited in the literature review demonstrate that like the representation of the body, our emotions, social displays of emotions, the relevancy of happenings, and the local moral order have changed over time and that the meaning and purpose of these changes are often difficult to define or even understand (Harré 1986). Nevertheless it would appear, judging from the narratives given by counselled respondents in this study, that counselling for them has brought some order to the sea of emotional chaos that post-modern times presents.

"She helped me understand what had happened. At the time when it happens you feel a bit bewildered and you are not really sure of where you are in life (counselled correspondent)."

Lutz & White (1986:417) maintain that "the concepts of emotion emerge as a kind of language of the self - a code for statements about intentions, actions, and social relations" and are important in forming the actor's sense of his or her relation to the social world. It is not my intention to enter into a long-winded discussion about the rudiments of emotion, since this subject has been covered at length by many social scientists (Russell 1991), but suffice to say that emotions appear to be "socially shaped and socially shaping (Lutz & White 1986)." This theory is supported in this study by showing that not all cultures have the same emotional reactions to pregnancy loss; the Abelam of Papa New Guinea believe miscarriage is the result of the *Wala* spirits influence, the Jamaicans maintain that a pregnancy that does not reach full term is a *false belly*, and an Asian respondent from Middlesbrough believes it was an act of God and there is nothing to be done about it. Nor do emotions have the same cultural meaning or significance in different societies. Grief,

or *liget* manifests as rage or anger to the Ilongot, which could only be satiated at one time by beheading someone.

It was found in this study that some men were affected by pregnancy loss in a similar way to the Ilongot, and needed counselling to help resolve feelings of rage and anger. According to Kohn & Moffitt (1994) although it is recognised that some men do react in anger to certain situations, in their opinion it is in an effort to conceal their true feelings. In other cultures society has created ways of allowing people to express their anger in an acceptable manner, however, in western society, head hunting is not an option. According to Stewart & Dent (1994) after bereavement the family dynamics can change and the father may feel he has been pushed outside of the family circle. Many fathers continue to hold down a job as well as ensuring the household continues to run smoothly while his partner is recovering. The father can be away from the home for long periods of time, working in conditions where there is no one with whom he can discuss his anxieties. Therefore men often suffer from unresolved grief or delayed grief reactions that might re-surface at some time in the future (ibid.).

Nevertheless, Douglas (1975:65) refers to the suffering of men in unison with their partner during pregnancy as *couvard*, usually associated with weak definition of marriage, or a strong interest on the husband's part in asserting his claim to the wife and her child. Douglas suggests that in England *couvade* might be found in sectors of society where the husband is absent from home for long periods. "The *couvarding* husband is saying, 'look at me, having cramps and contractions even more than she! Doesn't this prove I am the father of her child (ibid).'" However, Douglas asserts that this is just another strategy that individuals use to manipulate their social environment. Perhaps men who need counselling along with their partner are exhibiting a version of *couvard*, since it was found that men's need for counselling is greater when there are difficulties in their relationship with their partner or when a pregnancy is terminated for foetal abnormality. But if the emotional reactions to life events has changed to such an extent that counselling is the only way that some men and women can cope with crisis, then it stands to reason that the counsellor, or the counselling sessions, might bring about a change of awareness in some way!

7:2 The Relationship Between Counsellor and Client

There are many categories of counsellors who practice counselling in a variety of ways, making it difficult to get a clear picture of the counselling milieu (Howard 1996:24;Murgatroyd 1996). The counsellor is often portrayed as detached from, and yet at the same time, having a superior position in the counselling proceedings. According to Reddy (1996), counsellors are often described as qualified professionals who supposedly have some level of superiority over a client or legal sanction that enables them to perform counselling.

"The overall aim of counselling is to provide an opportunity for the client to work towards living in a more satisfying and resourceful way... Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis', developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others. The counsellor's role is to facilitate the client's work in ways which respect the client's values, personal resources, and capacity for self-determination (Howard 1996:24)."

These words, taken from the British Association of Counsellors' Code of Ethics, describe the role of counsellor as one of 'facilitator' in the practise of counselling. The counsellor is represented as an outside agency in the counselling sessions, having no involvement other than keeping the client's mind on the issue of resolving his or her social problems but also, at the same time, inferring a degree of superiority over the client who is deemed incapable of sorting out his or her own problems. That some respondents do think of the counsellor as being remote from the proceedings, and/or in some way superior to themselves, was evident in this study, although this was often put down to the fact that the counsellor was wearing a midwife's uniform. However, some respondents assumed that because the counsellor was also a medical professional she might not have their best interests at heart and would be more inclined to side with the doctors, especially when respondents had a grievance with the medical treatment they received at the hospital.

"She was always in a uniform when she came and I think really, to be honest it gives you a feeling of they are more in authority.....And then I think sometimes that can make you feel a bit, sort of maybe intimidated (respondent/counselled)."

"She was good but I think it was the fact that she was a midwife that I put some barriers up. I couldn't get it off me chest (respondent/counselled)."

"I felt that with her being a midwife she more or less banded with the doctors anyway, so she wouldn't even put your interests first. As a midwife, she sort of like, sided with the doctors (respondent/counselled)."

According to a midwife/counsellor, patients' need to be educated about how they should conduct themselves when consulting with professionals, since in her opinion it is the patients who consider themselves to be unequal or inferior to the professional and not the other way round. However, this excerpt taken from the same midwife/counsellor's transcript does imply that her earlier words were rhetorical.

"That takes quite a big change for patients who see themselves as weak and subservient to go in front of an expert when in actual fact they have a need, and this person is going to provide some information for them to take away and decide what they want to do (midwife/counsellor)."

Here the midwife/counsellor states that patients' see themselves as weak and subservient and that the professional is someone who can help them make a decision. But perhaps the true implication is that medical professionals see themselves as being the ones with the 'special' information that patients need, and therefore as having superior status over patients. Since women already feel at a disadvantage there is little chance they will muster the confidence to speak to a consultant, or even a midwife/counsellor, on equal terms, and definitely not to ask them to explain themselves. By tradition the doctor/nurse/patient culture inhibits this kind of relationship and the gulf in communications seems to be as wide as ever (Symonds & Hunt 1996). But this is perhaps because the majority of consultants are men and as Laderman & Roseman (1996:294) argue, it is the male dominance of female sexuality that adds to the disempowerment of women. Even midwives acting as counsellors to patients in their own homes might be a way of extending male dominated medical influence or control further into women's lives (McCourt (1998:37).

Kleinman (1988) maintains that the client or patient is often represented as a passive, compliant object in the therapeutic session because he or she spends much time in the role of 'sick person', and is therefore, perhaps, perceived by self and others to be ineffectual.

"It made me feel a little bit weak, as if I needed some help. And I did feel as though, not beneath me to ring, but I felt as though only me needed counselling which is the wrong thing to think (respondent/counselled)."

Yvonne McEwen (1999) says that people are now willing to take on the role of weak person, or victim, because the rewards can be significant, such as getting recognition for their suffering from society and even financial compensation in some instances. However, McEwen maintains, "not every culture needs, wants, approves or allows for victim status. It is perceived to be unhealthy and un-helpful for the long-term development of the individual or the community." But is this image, where the counsellor is clinically removed from the proceedings and is deemed to be superior to a client who sees him/herself as a passive victim of circumstance, a fair representation of the counsellor/client relationship? According to Kleinman (1988), it is not, since the patient and the practitioner bear reciprocal responsibilities.

Denzin (1989:44) states that there is an emotional bond created between counsellor and client, which Howe, (1993:40) refers to as the 'therapeutic alliance'. This concept dates back to Freud who believes that in therapeutic situations the strength of the alliance, and therefore the outcome of therapy, depends on two criteria; "the strength of attachment that a patient has made with a therapist and the treatment process, and the degree of friendliness, affection and sympathetic understanding shown by a therapist towards a patient (ibid.)."

The majority of counselled respondents spoke of their admiration and respect for the counsellor's abilities, and in many instances believed a friendship was formed between themselves and the counsellor, thus confirming a rapport was established, at least from the client's point of view. Kleinman (1988:247) states that the association of practitioner and patient in psychotherapy is a deeply moral relationship. The practitioner attempts to empathise with patients' suffering and becomes a moral witness, neither judging nor manipulating. In turn the patient becomes an active contributor and not a passive participant, and both learn and change from the experience. However, perhaps healer/patient relationships are not as simple as Kleinman suggests. Budd and Shama (1994:17) point out that all healing bonds rest on the assumption that the healer has something that can make a difference to the patient but it might be the case that the

patient does not want to be cured. Also, since the healer is not passive in the healing relationship, having views on whether or not the patient can, or should, be cured, these views will affect the amount of encouragement given to patients to change life style or narrative. Furthermore it cannot be ruled out that it might be the healer who is in need of a cure, as Kleinman himself suggests in his discourse on the 'wounded healer and the need to be of use' (1988:211).

Counselled respondent: "But I must admit when it got to the end I felt a bit guilty about not having her again, as if I was putting her out of a job. I know she had other people to see, but I did feel a bit guilty that I didn't need her service anymore. I felt as though it was a personal thing to her, you know. I would have been quite happy saying, yes come along cos you do get quite friendly with people, and I did feel a bit guilty about that."

Interviewer: "Not because you needed the counsellor but that the counsellor needed you!!"

Counselled respondent: "It's like turning the table round a bit! But when she started laying on the settee and I had the pen and paper, it was getting a bit much!"

This account was an isolated incident and no other respondents had detected a reversal of roles², or at least did not mention it during the interview. However, it does illustrate the friendliness and rapport that can exist between counsellor and client and that the therapeutic alliance is a shared experience for both parties involved. It might also explain, to some extent, why those alliances terminated by the counsellor in the study did not achieve the same level of satisfaction, or problem resolution, as those terminated by the respondent. Twenty five percent of counselled respondents thought they should have received counselling for a longer period of time and in all instances the counsellor had terminated the counselling sessions. It appears that total problem resolution is more likely to be achieved when the client is ready to relinquish the bond, and not the counsellor. Perhaps there is a certain point reached in counselling where the client achieves problem resolution status and if the sessions continue past that point the focus then turns toward the counsellors' problems!

² The role reversal in ritual is discussed by Turner (1995:166)

7:3 Increased Popularity of Counselling in Society

Patients and professionals were asked if they thought counselling is becoming more popular in today's society and why this might be. Some professionals suggested counselling's popularity might be due to the decline of the family unit or the secularisation of religion, in accordance with Giddens (1991).

"It is a symptom of the age when the welfare state is responsible for total health care of patients despite God or whatever. In the past it was accepted there would be a degree of foetal loss. This is no longer accepted in modern culture. There is a need to blame somebody, preferably not themselves. People now don't have religious beliefs to help them through life crises. It is a different culture. In the past when a mother lost a baby the general practitioner would talk to the family. He would be doing the counselling. Family were around, they lived in back to back houses and communities were very close. Families lived on each others door steps (consultant/interview)."

Although none of the patient/respondents suggested the increase in counselling is due to a lack of religious beliefs in our society, five counselled respondents who attended focus group (A) openly discussed their religious views about their loss. Some said their faith had grown stronger because of their loss but others were angry that God could have let such a thing happen to them. One respondent said the vicar told her to shout and scream at God to let Him know how dissatisfied she was. According to a health professional, counselling has not taken the place of anything, as suggested by Giddens (1991) and Heelas (1996), but is in addition to family and religion, "just a new thing that people feel is going to help them through, something like a computer or a washing machine."

Of course it cannot be forgotten that the media often play a large part in what is fashionable in society. As one respondent suggested, counselling might be in style because of chat shows and *soaps* on television, especially those from America where having a counsellor is the 'fashionable thing'. It was also pointed out by a counselled respondent that in local colleges counselling courses are now advertised along with interior design and Indian head massage and people who are not necessarily interested in becoming counsellors enrol just to pass the time. Although all respondents agree that the '*counselling cult*' is becoming more popular in society not everyone believed this was an indication that counselling is accepted as totally acceptable or respectable. As a control group respondent pointed out "some people think you're nuts if you go to a counsellor,



like weak and not able to cope with life." Even respondents who had counselling thought there might be some disrepute attached to it.

"There is a stigma though with counselling. One of my colleagues at work said 'do you still have that woman?' and it was just the way she said it, I thought 'oh she thinks I'm a nutcase'. I just felt as though she thought you know you have a counsellor because you're weak (respondent/counselled)."

Some respondents thought the name 'counselling' should be changed to distinguish between counselling administered by professional counsellors and fashionable counselling given by lay people with no qualifications. But, according to a health professional, the cultural climate is changing and while in the past counselling might have been frowned upon, as a pastime of the mentally impaired, today there is no shame attached to being counselled. People are counselled for all kinds of problems, marriage difficulties, violence in the family, as well as bereavement and pregnancy loss, because they are no longer prepared "to sit and suffer in silence (professional/interview)." However, some respondents believe the increased popularity of counselling is due to a 'change of the times' and that people are becoming more aware of what they need. "If they've got a problem they want to talk about it." It was also suggested that people have counselling because the attention they receive makes them feel good about themselves, signifying that the efficacy of counselling might be because of its performance value.

7:4 Public Performances of Grief

Although many cultures throughout the world stage huge performances of grief, in the West grieving has tended to be, although often elaborate, a more sedate affair. However, the 'golden age' of grief of the Victorian era (Littlewood 1993:77) fades in comparison to the performances of grief we are presently witnessing. Whereas grief was once a process that bereaved families shared within the confines of their own home, apart from the funeral, people are now finding more respite from grief by going public. Parents from various parts of the world publicise their grief by displaying foetal scans and photographs of their dead babies on the Internet, which some people might find extremely alarming. This outward display of grief by bereaved parents, who say they find consolation in publicly affirming their grief, is in stark contrast to the traditional social response to pregnancy loss in the past when it was considered a profane event. I asked one bereaved

parent from Canada, during an interview by email, why she thought that people feel the need to advertise their grief on the Internet:

Respondent: "I think it is because the parents who have lost children, especially babies, are starting to recognize that they need the support. We need to be able to talk about our children. Our baby was a part of us. Does she deserve less recognition than someone who lived longer? We don't think so. Parents of children who have died are speaking up so others will have some understanding of what they go through. This way, we don't feel so alone."

Interviewer: "Did sharing your story with others help you come to terms with your grief?"

Respondent: "Absolutely! Sharing her story had a healing effect. It is hard to explain; but, I'll try my best. When my daughter was diagnosed with the problems, I was heart broken. I started to search for a reason and how this could glorify God in our lives. Telling others her story allows me to share the Lord with them, in some small way. It gives her life and her death, purpose and meaning to me. Not just short term, but in the long run. Like I said, it is kinda hard to explain HOW it helps. I only know that does. It allows others to see the hurt, and in some small way, understand what I have gone through. When others know how I am feeling, they are more sensitive. This helps the healing process."

Interviewer: "Many women interviewed here in the UK have photographs of their babies and some are enlarged and displayed on the living room wall. Does this happen in Canada or is this tradition peculiar to the English?"

Respondent: "I have met several other ladies who have lost babies. We all have pictures, even if they are only ultrasound. I have a collage of pictures that were taken, I am in the process of hanging them up. I haven't done it before now because it had been too painful to have them visible all of the time. But, like others that I chat with, they will be seen." (Interview by email August 2000)

Perhaps Freud would have regarded this dependency on external objects for solace, which could include the deifying of photographs and the collecting of footprints and locks of hair, as a form of neurotic behaviour resembling sympathetic magic, which he refers to as "the mistaking of ideal connections for real ones". But Young (1993:210) argues there is a thin line between so called neurotic behaviour and sympathetic magic. Although he agrees that those who engage in this type of fixation run the risk of becoming bound to false gods and fetishism it can also lead to life enhancement, acting as it does as "a temporary stay against darkness and despair (ibid.208)." Turner (1987:81) might have

said that this was a classic example of a performer revealing 'himself to himself' through the reflexivity of 'his' performance. However, although the interviewee might gain respite from grief because of her performance we are left in no doubt that she believed she was doing it for other reasons; to gain sympathy and understanding from the audience and to help others in a similar situation. Yi-Fu Tuan (1995:242) says that spectators can enjoy the performance of a tragedy, even though they are utterly repelled by what they see. Not that people enjoy seeing others in despair but because the un-afflicted can rejoice in the fact they are not having the same problems, although this point is debatable.

Apart from displaying photographs of their dead baby in the living room of their homes parents on Teesside also have another way of coping with grief. Care For Bereaved Parents (CFBP) have prepared a Garden of Remembrance at South Cleveland where parents can sit quietly to commemorate their lost child. Four annual ceremonies are arranged at the 'Parents Wall' in Acklam Cemetery, where parents gather to give support to each other. In July 2000 I attended a ceremony where more than fifty parents listened to inspiring music and readings that were presented by the hospital chaplain with the help of some of the parents themselves. Each parent was given a white balloon on which they wrote a message to their dead child before floating it off into the atmosphere. Unfortunately some of the balloons became entangled in the trees and remained earth bound, which was very disconcerting for parents. Afterward parents, the support worker, and the hospital chaplain reassembled at the Botanical Gardens for coffee and biscuits. Those attending the remembrance service who were respondents of this study said that even though they had come to terms with the loss through counselling it was comforting to know they could attend a remembrance service when they are feeling particularly mournful, which is often around the anniversary of their loss.

That performance can alter social structures and create new meaning for performers and spectators is a theory subscribed to many social scientists (Lindquist 1997; Turner 1982; Jennings 1992). An email interviewee (2001) supports this theory. After having lost a child of fourteen months, had a termination for foetal abnormality, and nine miscarriages the interviewee now lectures on her experiences at York University in Canada. She says that talking to others has alleviated her grief and she hopes she can help others to do the same. The interviewee's lecture begins with a graphic description of her losses and leads

on to a declaration of a change in consciousness. "I have joy in my life again and there is now light where once there was only darkness. I have moved forward with my life (email interviewee 2001)." Taussig (1991:199) discusses the relevance of dialectical, or thought provoking imagery in a performance as a catalyst to fire the imagination that he believes is a method of giving "absolute form in a genuine way to the immanent condition of fulfilment, to make it visible in the present." Such imagery, although often offensive to the uninitiated, can act as a catalyst to free the 'deadening hand of tradition'. This could be seen as a process of reflection, whereby society imposes certain cultural beliefs on people, who in turn respond in a manner that could in time change cultural beliefs and practices.

7:5 Counselling: a Ritual of Post-Modern Times

Counselling too is a dialectical performance where clients make their feelings about an event more visible or coherent by talking to a counsellor. Mattingly (1998) states that narrative is an important component in the problem solving process of counselling since clients are encouraged to relate the story of their experience in the hope that the narrative will become changed in some way, thus helping clients to transform self-identity. Having the chance to narrate their own particular story of loss seemed very important to the respondents, since the majority of them related in detail the gory account of what had happened to them, before being asked any questions about their experience of the counselling service. Even those respondents who did not have counselling spoke about how important talking to someone about their experience had been in helping them come to terms with their loss.

"In my opinion - me and my husband got a lot out of losing the babies in the respect that it made us talk and if you can talk about something like that, then you tend to talk about everything. I talked to my mum about it. I talked to me sister about it, and just generally, just talking it over to my husband. Talking stopped it being such a big problem, because to me if I was going for counselling I would have to psyche myself up for going, then know that what you were going to go and talk about and just even thinking about it would be upsetting. Whereas I could be round mum's and all of a sudden I'd just feel like crying and I could cry it out. It was actually what happened rather than a very forced situation, and because it just happened, I don't think it ever got to be a problem that I needed counselling, but I probably had it (respondent/control)."

Although for this participant having counselling would have seemed like a forced situation she still thought that talking about events is important and that counselling is 'about talking'. In Turnbull's (1995:75) experience the most significant discoveries that provide a basis for fruitful subsequent investigation are made in those moments of abandon, when events are not rehearsed but allowed to unfold naturally.

Turner (1992:81) suggests that if we scan the rich data put forth by the social sciences and humanities on performances, we can class them into 'social' and 'cultural' performances. The self is presented through the performance of roles and through declaring publicly that one has undergone a transformation of state and status resulting in a new identity. According to Fernandez, (1995:22) we all strive to be in a state of 'grace' and have a desire for the "achievement of radical transformation of the wretched self into something other, something more graceful." Our disgraceful state is highlighted when the possibilities of our imagination are unrequited and sooner or later we have a self-conscious desire to go in search of grace (ibid.). Rituals performed in the UK until recently, such as the *churching of woman*, allowed women to extricate themselves from the defilement of childbirth returning them to a state of grace, and possibly those who suffered stillbirth or miscarriage would at the same time be absolved of any feelings of guilt or shame. The discourse between the priest and the woman had the effect of changing her self-identity in some way so that she returned to the world leaving her sinful state behind her. Since religious rituals have largely been abandoned in the West, women who suffer a pregnancy loss are presently regaining self-identity, or a state of grace, through the ritual of counselling.

Myerhoff (1990:247) discusses Rapport's (1968) theory that all ritual performances are based on lies; a ritual performance being a kind of 'lets pretend' situation where people appear to have forgotten reality. This too has an analogy with the ritual of counselling since the client is in the process of inventing a new future that is not based on the client's perception of their self-identity as it was before the counselling sessions first began. The client begins the counselling sessions believing themselves to be of little use to self or society and emerges after counselling as a new person. But Rapport maintains that lying in rituals is both common and permissible since all that is socially required is a statement of belief from the individual that they have undergone a change in consciousness or

status. In Myerhoff's opinion, rituals have the propensity to disguise reality, portray fictions and to save face. "Rituals allow people to manoeuvre, fight on their own terms, choose the times, places, conditions, and shape of their claims (Myerhoff 1978:107)." But Giddens (1991:29) argues that transformations which take place in this way put the client at risk of relapse since the transformation is not based on tried and tested traditions, as it was within conventional religious settings.

One control group respondent agreed that there is a need to believe in something or someone to help the person move on after a life crisis, although she believes it does not necessarily have to be through organised religion or a counsellor.

Interviewer: "What about beliefs, do you think they are important as well in helping you overcome a crisis?"

Control respondent: "Definitely, You've got to know where to draw the line as well, I think. You've got to put your life back on the right track. I've heard of some people who've had babies and they've got the photographs on the side. I don't think that's very positive - that's my opinion, everybody has got their own way of dealing with the situation, but you've got to have some belief. You don't have to believe in God if you can believe in one person in helping you. [in this case it was her mother] You do need something to get you back onto the right track of a normal way of life (control respondent)."

Comer (1996:246), states there is a line between religion and ideology, although upon close examination it appears fuzzy. While religion assumes the intervention of supernatural forces, ideology must resort to things other than supernatural, but in the end people from both sides of the line have a need to regard their lives as meaningful and contributing toward the attainment of some earthly paradise. Ideology provides a symbolic framework to replace the religious symbolic structures that have been discarded or abandoned because it is believed they can no longer accommodate or support present day happenings in the world. Making sense of the world is the first priority of humans and if sense cannot be made "anxiety is generated that precludes effective behaviour (ibid.:248)." Comer (1996:247) argues that ritual is inseparable from either religion or ideology and that all rituals provide a model for the current social configuration and one's place within it. According to a midwife/counsellor counselling provides a similar service.

"Counselling allows the person to look at what it is that's going on at the time and give them some control back in their life to allow them to move forward in the way in which they would choose to do (Midwife/counsellor)."

Comer (1996:23) speaks of the ideological ambitions of ritual that spur people on to an imagined future which he believes is really a nostalgia for an idealised past. All sections of modern society have rituals and specific credentials are required for these specialised theatrical roles. Those who fall short of a particular social model for one reason or another are excluded from meaningful participation in the rituals and have to find a basis for identity elsewhere (ibid:46). Women who fail to fulfil the expected female role of child bearer are excluded from the rituals of motherhood for which they were preparing. Many of these women remain in a liminal or a marginal state, living on the edge of society until they can rid themselves of their embodied inferior status and re-form *communitas* with the rest of society (Turner 1995:166). This exclusion from society that western women experience following a failed pregnancy might not happen in some cultures where rituals are performed throughout pregnancy. The separating rituals of the Zulu (Callaway 1993) and the Toda (van Gennep 1960), appear to give women a ready made cultural narrative to take them from one status of being to another during the birthing process before they are finally reintegrated into society. Also the belief of the Arunta, Kaitish, and Warramunga of central Australia, where a liminal period of up to forty days after birth is allowed for the soul to enter the body, are perhaps more supporting of females' continued social position (van Gennep 1960:53).

Nevertheless, when it comes to analysing the emotions and actions of other cultures, or of professing to know their minds or reasons for ritual performances, we must remain alert to our ethnocentricity (Rosaldo 1993:4; Fernandez 1995:25). Rosaldo gives an example of his own ethnocentricity when he first carried out his fieldwork among the Ilongot headhunters from 1967 – 1969. At that time he did not truly comprehend the rage and anger that the Ilongot experienced in bereavement or why they head hunted. He was of the opinion that the death of the beheaded victim was by way of cancelling out the death of the Ilongot's next of kin, thereby balancing the ledger. It was not until he revisited the Ilongot in 1974 and was told by an elder that this was not the reality of the situation at all, that he began to re-examine their motives for head hunting. By 1974 the ritual of head hunting had been abandoned by the Ilongot after rumours that firing squads had become

the new punishment for head-hunting in the Philippines, and headhunters were finding their grief and rage in bereavement unbearable to live with. However, it was also around the same time that the Ilongots considered conversion to evangelical Christianity as a means of coping with their grief. Rosaldo then thought that converting to Christianity would make coping with bereavement less agonising because they could believe that the deceased had departed for a better world. No longer did they have to confront the awful finality of death. But once again Rosaldo had misunderstood the motives of the Ilongot.

"The force of the dilemma faced by the Ilongots eluded me at the time. Even when I correctly recorded their statements about grieving and the need to throw away anger, I did not grasp the weight of their words (Rosaldo 1993:4)."

Rosaldo believed that the new religion gave the Ilongot a chance to deny the finality of inevitable death but an Ilongot friend snapped at him saying that this was not the reason, it merely gave them a means of coping with grief previously provided by head-hunting. If they were to remain in their previous Ilongot way of life without performing the ritual of head-hunting the pain of sorrow would be too much to bear. The conversion to Christianity merely gave the Ilongot a new way of coping with rage and grief and was not, as westerners might believe, a way of denying death. Rosaldo now maintains that the dilemma for the Ilongot grew out of a set of cultural practices that, when blocked, were agonising to live with, a dilemma that one could compare with the notion that it is the failure to perform rituals that can create anxiety. For the Ilongot any type of ritual helped them to overcome grief, whether it was associated with head-hunting or Christianity.

7:6 Toward an Anthropology of Counselling

Because this study took place on Teesside and the overwhelming majority of respondents were British, the results have concentrated on how counselling helps in the management of grief for British people. The role of counselling for ethnic minorities could not be assessed to any extent since only two Asian respondents took part in the study. One Asian respondent had counselling because she needed reassurance that she had not been used as a guinea pig at the hands of the medical establishment and the other was a control group respondent who listened while her husband spoke on her behalf. Both women belonged to strong extended family units. But as Corey (1996) points out, people who come from different cultural backgrounds might not have a need for counselling, as we

understand it. Because Asian individuality is surrendered to social solidarity, the family unit, and religious beliefs, all issues which are of paramount importance in their lives. At the present time their beliefs and the rituals performed within their own religious setting allow these people to accept what has happened to them in a fatalistic manner: "If God's going to give you something, he's going to give it to you. If he's going to take something off you, he's going to take it (husband of control respondent)." But just how second and third generation Asians living in this country will cope with life crisis in the future, if they move away from traditional cultural practices as many of them are now doing, will be interesting to observe.

Since counselling has only recently become available to the masses, previously being a pastime of the rich and famous, it is difficult to estimate what its eventual impact might be on society. Likewise it is challenging to describe exactly what counselling is or what it does (Davis & Fallowfield 1994:23), save to say that many people who have counselling believe it has allowed them to overcome the effects of trauma and grief to move on in life. To ascertain a meaningful description of counselling the generic differences between cross-cultural healers, such as doctors, shaman, witchdoctors, spiritual healers and counsellors etc., would need to be established. Also issues relating to theatrical roles and power roles, of both healer and client, along with an identification of the variances in performance that might manifest according to gender, race, age, social class, religious beliefs, education and language need to be addressed.

The fact that communication in healing relationships is largely linguistic, implementing metaphor and symbolism to describe meaning, indicates the context of any counselling session would rely upon the semantics or 'propositional' content of speech used in counselling (Bloch 1989). As a consequence, what is said, how it is said, and what it represents to the listener, would vary according to social and cultural circumstances, which includes all of the above categories. In the counselling situation both verbal and non-verbal communication is essential and the embodiment of a client's social circumstances could affect their self-expression and understanding of meaning. According to Argyle (1996), men and women behave rather differently in the sphere of communication. For instance, women talk with women and use different bodily gestures than they do when conversing with men and likewise communication between two men

also differs. This fact is also true of people from different cultural backgrounds, colour, or class systems. Traditionally the language (dialogue) used by counsellors is often stylised or ritualised in some respect. Counsellors use phrases such as "and how does that make you feel" in response to the narrative of clients, which can be verified by the writer's own experience in counselling training. The form of dialogue and the degree that counsellors use a set repertoire of clichés could influence clients' perception of counselling, and also have a bearing on the eventual outcome. Several anthropologists have explored the significance of linguistics in ritual, Malinoski (1955), Leach (1968) and Tambiah (1973), and according to Bloch (1989:20), the potency of language, and therefore its effect upon clients, depends very much upon the creativity of syntax.

Language used in the healing contracts might also dictate where the locus of power resides in counsellor/client relationships. In today's society empowerment of the individual is being strongly promoted, especially in counselling situations where counsellors maintain it is the client who sets the pace and the agenda of the proceedings (Hindmarsh 1993). However, if clients enter the healing arena with an embodied experience of inadequacy their capacity to take control of the proceedings could be severely hampered, especially when faced with a professional counsellor who clients might see as being more 'powerful' than them in some way. These differences in perceptions of powerful status might differ in same sex and opposite sex situations as well as cross-culturally. Added to this there are issues relating to the milieu of counselling and how this might influence the empowerment of clients and raises questions such as, are clients more empowered when counselled in their own home as opposed to a medical setting?

Representations of both counsellor and client are also important. How does the counsellor see his/her role in the counselling arena and in what light do they view the client and visa versa? Clients are usually represented as people who see themselves as less significant in a healer/patient relationship, according to health professionals (Klienman 1988), but how do clients characterize themselves? Do counsellors conclude that the situation of all clients is problematic on the basis that the client has made an appointment for a consultation, thereby making generalisations about clients? And perhaps most essentially, to what extent does the observer/researcher's representation of

self and ethnography influence the critique of a study? According to Edgar and Russell (1998:5), "representations, linguistically and symbolically codified, are seen as creating social reality rather than just reflecting it", therefore the performance of an observer is of supreme significance in the creation and manipulation of the narrative that respondents bring to a study. These issues could be researched and expanded upon in a doctoral thesis.

For my own part in the present study, what originally started out as an evaluation of the effectiveness and efficiency of the counselling service at South Cleveland Hospital has evolved into a study of one of the most profound complexities of society and as a result has brought about a transformation in my own consciousness, although I did not realise this until the work was completed. I also believe that the consciousness of the respondents might have been transformed in some way because of my reactions to their sorrow, the nature and format of the questions I asked, and the manner in which I presented questions to respondents. Although I was not giving counselling to the respondents they did have the opportunity of going through the performance of grief one more time, which, according to Humphries & Laidlaw (1994:82), can bring about changes of perception in participants, thus bringing ever closer a transformation in the western cultural narrative concerning pregnancy loss. The main points of the study are summarised in the final chapter.

Chapter Eight: Conclusion

The Ever Changing Kaleidoscope of Cultural Narrative

Over the last few centuries pregnancy loss and the social reactions to loss have changed dramatically. Historically, the performance of human reproduction was seen as a magical phenomenon and regarded as a female mystery universally associated with the moon (Donnison 1988:15). Miscarriage and stillbirth had their place in society and babies who were lost in this way were not only given respect but were also revered as having healing properties. Many fertility rituals were performed to attract the beneficent power of the moon and other good spirits as an aid to healthy reproduction. Along with Christianity came new vocabularies, which included the doctrine of original sin, and the belief that every child entering the world was impure until the sin was removed by baptism. With the rise of patriarchy women were losing their grip on what had always been a female domain until eventually women themselves were accused of killing their babies for malevolent purposes. Since the early 1900s the theatre of childbirth has become an increasingly male dominated activity where different professions constitute a 'quasi-kinship system', with doctor and midwife playing the paternal and maternal roles and the patient as the child (McCourt 1998:34). The practice of childbirth was moved from the community to the hospital where women were encouraged to believe their bodies were not capable of delivering a baby without the aid of modern technology, but women were also assured of a 'safer' birth. More recently, mostly because of the influence of the *Changing Childbirth Report*, (1993) the locus of birthing has once again moved back into the community with midwives playing a more central role (ibid.). This report was also the impetus for the development of the counselling service for bereaved parents at South Cleveland Hospital.

Nevertheless, counselling has not been kindly received in all areas of the medical profession, not only because of the extra financial burden it imposes on an already over stretched budget, but also because it has no proven therapeutic effect. According to Giddens (1991) counselling might eventually prove disadvantageous to people who are already in a position of vulnerability. However, many advocates of counselling believe it offers a system of support not available elsewhere in society, even when it is performed by unqualified individuals (Hindmarsh 1993). Despite disparagement from some health

professionals and social scientists the number of patients who received counselling in 1999 almost doubled in comparison to the previous year. The British Association of Counsellors also report an increase in inquiries for counselling and now receive as many requests for counselling in one month than they used to receive in a whole year. It seems that increasingly people who are traumatised by life events are turning to counsellors for support, but any long-term effects of counselling will not be known for some time to come. Nonetheless, the counselled respondents who took part in the study believe they have come to terms with their bereavement much faster because of counselling. According to Mattingly (1988:52) therapists help patients overcome their problems by assisting them to generate new story lines to live by when their old direction in life is no longer acceptable. Thus it could be said that counselling brings about a transformation in consciousness in the patient and perhaps in the counsellor too, as Kleinman suggests (1988:211).

In essence counsellors and therapists might be seen as negotiators between the patient, their dysfunctional problems, and their cultural traditions and beliefs. Although sharing experiences of bodily distress can lead to greater bodily attention, and as such is a reinforcement to a woman that her body is not fulfilling its socially designated role of child bearer, Becker (1997) maintains that it also facilitates social action. This would seem to be the case with pregnancy loss since we are beginning to see some indication that women are no longer prepared to stay silent about their experience but are demanding to be heard within the family and society. The advertising of grief and mourning on the Internet, with photographs and obituaries to dead babies, could be construed as the rise of a new public mourning culture or the re-emergence of the elaborate mourning periods of the Victorians, described by Littlewood (1993). Both serve the same purpose since the performance of grief is a representation of self in society, the reflection of which might help them and others make rhyme or reason of their embodied experience (Turner 1967).

Counselling too might be seen as a performance within the mourning arena. According to counsellors at South Cleveland Hospital techniques used in counselling give clients an opportunity to re-gain control of their feelings after a pregnancy loss, thus allowing them to move on in life. The performance of counselling in this study is likened to a ritual of post-modern times because of its capacity to allow respondents to transform their reality

by the creation of new narrative (Mattingly 1998). Although an exact definition of ritual is difficult to classify, and according to Turner the term ritual should only be applied to religious ceremonies or mystical experiences, other writers allege that all activities have ritualistic qualities that can bring about changes of perception in participants (Humphries & Laidlaw 1994:82). While Comer (1966:247) suggests that ritual provides a model for the current social configuration and expresses social order, ritual is also portrayed as a kind of 'lets pretend' performance, where people appear to have forgotten reality (Myerhoff 1990:246). However, Myerhoff remarks that while there are those who would say that forgetting is the very hallmark of rapture, and others who warn us of the madness of ritual, "the real danger comes with forgetting that we are always in a play of our own construction."

Giddens (1991:32) maintains that the increased popularity of counselling is because people no longer have the support once offered by traditional religious practices, and this seems to be a logical presumption. However, an examination of the historical record of traditional religion does not seem to have given too much support to women who suffered failed pregnancy in the past, given the fact that women who delivered or gave birth to stillborn babies were executed in the name of religion (Donnison 1988). Although Charlton (1998), Harris (1999) and other medical professionals argue that counselling is a 'waste of time and money' and Giddens describes counselling as a risky practice, since it is not based on the tried and tested traditions of organised religion, these points are contentious. While it is true that we have little 'scientific' evidence that counselling has any therapeutic effect, and it is only the testimonials of those who receive counselling that affirm its effectiveness in the management of grief, it might be said that the merits of counselling, as indeed any performance, lie in a different direction.

In as much as society is an ever-changing kaleidoscope of activity and accordingly, so are the ways in which society reacts to these changes, counselling in the event of pregnancy loss might be seen as a reaction to the fall from social 'grace' (Fernandez 1995:25) that some women suffer when they do not fulfil their socially designated role of child-bearer. Partaking in the ritual of counselling is an effort on their part to locate a 'desire' (Mattingly (1998:107) to regain social and self-esteem, which in turn allows women to establish a new self-identity in an ever-changing world. And as Rosaldo (1993)

eventually discovers during his fieldwork with the head-hunting Ilongot, it is not the method of ritual that dispels grief, but the opportunity to 'perform' rituals on a secular level that might be ritual's most empowering aspect, whether or not the facility is provided through head-hunting, organised religion, or by any other means.

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The writer acknowledges that the following research projects, scheduled to begin in 2001, might have a bearing on this study:

The Technological Management Of Childbirth: Risk, Empowerment And Accountability. University Of Plymouth Professor DJ Mason, Professor EM Ettorre, Dr GJ Lankshear & Professor KR Greene. January 2001 - December 2003.

Social And Ethnic Differences In Attitudes And Consent To Prenatal Testing. Leeds University & St James' University Hospital Professor J Hewison, Dr J Green, Professor HS Cuckle, Professor RF Mueller & Mr J Thornton June 2001 - December 2003.

Appendix 1 Recommendations for Improvement to Counselling Service

Proposals Put Forward by Patients During Interviews and Focus Group Meetings

- A midwife/counsellor should be there at the time of diagnosis in cases of foetal abnormality or as soon afterward as possible.
- A midwife/counsellor should advise patients about the possible consequences of the surgical or medical procedures used for induction in terminations or when the foetus has died in the womb.
- In cases of stillbirth or miscarriage the patient should be offered counselling by the midwife/counsellor before the patient leaves the hospital.
- When counselling is offered to patients the midwife/counsellor should state the amount of sessions the patient will have before the case is reviewed. If at the end of that period the patient still feels in need of counselling the midwife will decide if she should continue counselling the patient herself or whether it would be advantageous to bring in an independent counsellor. (In cases where patients have other unresolved problems apart from the pregnancy loss)
- Fathers and perhaps children and other carers should be offered counselling in their own right.
- Fathers should be encouraged to write a paragraph about how they felt at the time of the loss so that these can be added to the information leaflet and given to other fathers.
- A support group should be available to parents who feel they might benefit from talking to their peer group about the loss. Parents themselves if possible might run this group.
- All medical staff, including consultants, should have some training in counselling skills.

- Provision should be made for patients to be given an explanation of their baby's abnormality and reason why the loss occurred.
- The word '*counselling*' should be changed to distinguish between counselling delivered by a professional for medical related issues and fashionable counselling given by a lay person or none professional counsellor.
- An independent counsellor who is trained as a midwife but who no longer works at the hospital should give counselling in pregnancy loss.
- Midwife/counsellors should produce a leaflet for patients giving an explanation of what counselling entails and its supposed benefits.

Proposals Put Forward by Professionals During Interview

- All people involved with counselling, whether from the gynaecology, infertility, obstetrics, or antenatal services, should sit as a core group and have an accepted mission statement or rethink as to how they are going to perform this service.
- A midwife/counsellor should be available Monday to Friday to support people at diagnosis.
- A counsellor should be informed when a pregnancy loss takes place so they can visit the patient before they leave hospital.
- The counselling service should be available to midwives as well as patients because sometimes midwives find it difficult when they deliver a dead baby and often blame themselves for the death. If they went over the experience with a counsellor they could learn from the situation in a safe, confidential and secure environment.
- The service needs to be monitored and controlled so patients are not counselled for the sake of it.

- All staff should follow a strict protocol when handling pregnancy loss so everybody knows what they are doing. This should include informing the counsellor when a loss takes place.
- A standard counselling service should be offered to women and a follow up phone call, if not an appointment made, so they can take up the option of counselling if they want to.
- The counselling service should not stand-alone but should fit in with the rest of the services offered at the hospital.
- Counsellors should be involved early on in pregnancy loss because a lot of work can be done before the patient returns home.
- The care and support worker and the midwife/counsellor need to be managed together so that they compliment each other.
- The midwife/counsellor should play more of a counselling role and her midwifery input reduced.
- Local help-line should be set up, similar to that of the Miscarriage Association or other befriending services.
- Patients should not just be given a card and told to ring but should be given an appointment for counselling, which could later be cancelled or changed if they wished.
- The counselling service should be run as it was in the past, with the midwives from delivery suite because that was a very good system although it was difficult to prove it.
- With a standard bereaved patient who has had a stillbirth or abnormality, that patient should be brought back to discuss the case from the medical point of view with the consultant and the midwife involved in the case. If after that point there is considered to be a need for counselling then ideally it should be available.

- The original counselling service that was offered by the midwives in delivery suite should be re-instated.
- Couples should receive counselling post partum and if need be other agencies should be available to them for longer periods of counselling.
- There should be at least three midwives trained and involved at the core of the counselling service. Although the counselling service is good at the moment there are only so many hours in a day and if the counsellor is off sick or away, there is nobody available.

Appendix 2 Tables, Charts and Histograms of Results

Interviews with Counsellor Respondents

Fig.2a

Counsellor Group = 16 Respondents			
1. How were respondents made aware that the counselling service was available?			
Midwife/Counsellor	43.75%		
Hospital Information	50.0%		
General Practitioner	6.25%		
2. Would respondents feel uncomfortable requesting counselling from a midwife?			
Yes	62.5%	No	31.25%
Don't know	6.25%		
3. Where respondents given information about alternative counselling services?			
Yes	12.5%	No	81.25%
Don't know	6.25%		
4. Should bereaved patients be counselled by a midwife or an independent counsellor?			
Midwife	68.75%		
Independent	12.5%		
Don't know	18.75%		
5. Did the midwife's uniform have any effect on respondents?			
Yes	43.0%	No	57.0%
6. Were respondents helped by the counselling sessions?			
Yes	81.25%	No	6.25%
Small amount	6.25%		
Don't know	6.25%		
7. Was the period of time respondents received counselling long enough?			
Yes	62.5%	No	25.0%
Still counselled	6.25%		
Don't know	6.25%		
8. Who terminated the counselling sessions?			
Patient	50.0%		
Counsellor	43.75%		
Still receiving counselling	6.25%		
9. Should patients be approached by the midwife/counsellor or should they request counselling?			
Midwife/counsellor	75.0%		
Patient requests	25.0%		
10. Could anything further have been done to help respondents?			
Yes	81.25%	No	18.75%
11. Might other family members have benefited from counselling?			
Partner	25.0%		
Partner+Children	31.25%		
Don't know	12.5%		
No	6.25%	Missing	25.0%
12. Do respondents have strong family ties			
Yes	12.5%	No	50.0%
Don't know	6.5%	Missing	31.25%

Interviews with Control Group

Fig. 2b

Control Group = 9 Respondents					
1. How were respondents made aware that the counselling service was available?					
Midwife/Counsellor	0%				
Hospital Information	88.9%				
General Practitioner	0%				
Didn't know about service	11.1%				
2. Would respondents feel uncomfortable requesting counselling from a midwife?					
Yes	55.6%	No	33.3%		
Missing	11.1%				
3. Where respondents given information about alternative counselling services?					
Yes	22.2%	No	44.5%		
Don't know	22.2%				
Missing	11.1%				
4. Should bereaved patients be counselled by a midwife or an independent counsellor?					
Midwife	77.8%				
Independent	11.1%				
Don't know	11.1%				
5. Why did respondents not have counselling?					
Didn't need counselling	44.4%				
Not offered counselling	11.1%				
Don't speak English	11.1%				
Care & Support Worker helped	11.1%				
Too busy	11.1%				
Don't know	11.1%				
6. With hindsight, might respondents have benefited from counselling after their loss?					
Yes	55.6%	No	33.3%		
Missing	11.1%				
7. How did respondent come to terms with the loss?					
Family support	33.3%				
Care & Support Worker helped	22.2%				
Not one to dwell on it	11.1%				
Has not come to terms	11.1%				
Missing	22.2%				
8. Should counselling be offered by midwife/counsellor or should patients request counselling?					
Midwife/counsellor	66.6%				
Patient requests	33.4%				
10. Could anything further have been done to help the respondents?					
Yes	55.6%	No	44.4%		
11. Might other family members have benefited from counselling?					
Partner	22.2%				
Don't know	11.1%				
No	44.5%	Missing	22.2%		
12. Do respondents have strong family ties?					
Yes	44.5%	No	44.0%	Missing	11.0%

Results from Focus Groups A & B
6 respondents attended each focus group

Fig. 2c

Counselling service provided by midwives is needed						
Group A	F1	F2	F3	F4	F5	M1
Offered						
Asked	*	*	*	*	*	*
Group B	F1	F2	F3	F4	M1	M2
Offered	*	*	*			*
Asked						
Patients should be contacted by midwife/counsellor at time of diagnosis						
Group A	F1	F2	F3	F4	F5	M1
Offered	*	*				
Asked				*		
Group B	F1	F2	F3	F4	M1	M2
Offered		*	*	*		
Asked						
Lack of communication between medical staff and patients						
Group A	F1	F2	F3	F4	F5	M1
Offered	*	*			*	*
Asked			*			
Group B	F1	F2	F3	F4	M1	M2
Offered		*	*	*	*	*
Asked						
Were not ready to end counselling sessions						
Group A	F1	F2	F3	F4	F5	M1
Offered	*		*			
Asked				*		
Group B	F1	F2	F3	F4	M1	M2
Offered	*			*		
Asked						
Male partner found it difficult to cope with the loss						
Group A	F1	F2	F3	F4	F5	M1
Offered	*		*			*
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered	*	*	*		*	
Asked						*

Key:
F=female
M=male

Offered=
Respondent
offered
information
without
being
asked.

Asked=
Respondent
was
prompted.

Results from focus groups A & B continued:

Fig. 2d

Partners should not be counselled as a couple						
Group A	F1	F2	F3	F4	F5	M1
Offered	*		*			
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered	*					
Asked						
Pregnancy loss affected relationship						
Group A	F1	F2	F3	F4	F5	M1
Offered	*					
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered	*			*	*	
Asked		*				
Still in need of counselling now						
Group A	F1	F2	F3	F4	F5	M1
Offered	*		*			
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered						
Asked	*	*				
Bereaved parents need a support group						
Group A	F1	F2	F3	F4	F5	M1
Offered	*		*			*
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered				*	*	
Asked						
Support group should be run by professionals (P) or lay persons (LP)						
Group A	F1	F2	F3	F4	F5	M1
Offered	P		LP			
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered	P		P	LP	LP	
Asked						

Key:
F=female
M=male

Offered=
Respondent
offered
information
without
being
asked.

Asked=
Respondent
was
prompted.

Fig. 2e

Needed counselling sometime after bereavement-6 months to a year						
Group A	F1	F2	F3	F4	F5	M1
Offered	*					*
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered		*		*		
Asked	*					
Counselling after 3 months should be done by a midwife/counsellor (MC) or an independent counsellor (I C)						
Group A	F1	F2	F3	F4	F5	M1
Offered	IC		IC	IC		IC
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered	IC	MC	MC	IC		
Asked						
Respondents who mentioned that the loss had effected their religious beliefs						
Group A	F1	F2	F3	F4	F5	M1
Offered	*		*	*	*	*
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered						
Asked						
Men's thoughts concerning pregnancy loss should be included on a Bereavement Help Leaflet						
Group A	F1	F2	F3	F4	F5	M1
Offered			*			*
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered						
Asked					*	
Some medical professionals need to learn counselling skills						
Group A	F1	F2	F3	F4	F5	M1
Offered			*	*	*	*
Asked						
Group B	F1	F2	F3	F4	M1	M2
Offered						
Asked	*				*	

Key:
F=female
M=male

Offered=
Respondent offered information without being asked.

Asked=
Respondent was prompted.

Results from Interviews with 13 Health Professionals

Fig. 2g

1) Should counselling following pregnancy loss be carried out by a midwife or an independent counsellor?			
Midwife	83.0%		
Independent	8.5%		
Don't Know	8.5%		
2) Should all midwives counsel patients or should counselling be carried out by midwives who have specialised training in counselling?			
All midwives	0%		
Specialised	50.0%		
Both	33.5%		
Up to Midwife	16.5%		
3) Should all midwives be given grounding in counselling skills during midwifery basic training?			
Yes	100%		
4) Should counselling be offered by the counsellor or be requested by the patient?			
Offered	58.5%		
Requested	25.0%		
Don't Know	16.5%		
5) When should counselling be offered to patients who have had a pregnancy loss?			
At diagnosis	25.0%		
At time of loss	50.0%		
At a later date	16.5%		
All of the above	8.5%		
6) Do professionals ever advise patients that counselling might help them?			
Yes	75.0%	No	8.33%
No but might	8.33%		
Missing Value	8.33%		
7) Do patients ever request counselling before they are offered it?			
Yes	16.5%	No	50.0%
Missing value	33.5%		
8) Should counselling be offered to other family members?			
Partner	75.0%	Partner+children	58.5%
+Other carers	25.0%		
9) Who should counsel the family?			
Midwife	25.0%	Independent	25.0%
General Practitioner	16.5%	Don't Know	8.5%
Missing values	25.0%		
10) Could counselling have an adverse effect on patients and their family?			
Yes	58.3%	No	8.3%
Maybe	25.0%	Missing	8.3%
11) Did women who suffered pregnancy loss years ago cope better than women of today?			
Yes	0%	No	58.5%
Sometimes	8.5%	In a different way	16.5%
Don't know	16.5%		

Results from Questionnaire with 45 Health Professionals

1. Average age		41.16% years			
2. Sex		Male	2.2%	Female	97.8%
3.Job Description					
Midwife		86.6%			
Doctor		4.5%			
Nurse		6.7%			
Admin Staff		2.2%			
4. Average length of service		16 years			
5. Community or hospital based					
Community		38.0%			
Hospital		62.0%			
6. Does counselling have a therapeutic effect on bereaved patients?					
Never		0%			
Sometimes		71.0%			
Always		29.0%			
7. Who should counsel patients in cases of pregnancy loss?					
Midwife		40.0%			
Independent		26.7%			
General Practitioner		0%			
All above		31.1%			
Don't know		2.2%			
8. Who should make first contact to arrange counselling session?					
Counsellor		53.3%			
Patient		46.7%			
9. Would other family members benefit from counselling?					
Partner		40.0%			
Partner + children		35.5%			
+Other carers		46.6%			
10. Who should counsel family members?					
Midwife		13.4%			
Independent		53.4%			
General Practitioner		2.2%			
All of above		2.2%			
Midwife+independent		8.8%			
Independent + General Practitioner		17.8%			
Don't Know		2.2%			
11. Do you have any qualifications in counselling?					
Yes		26.6%			
No		73.4%			
12. Should instruction in counselling skills be included in midwifery training?					
Yes		88.9%			
No		6.7%			
Don't know		4.4%			
Respondents were asked why counselling is becoming more in demand.					
See discussion					

Fig.3a. 90% of Hospital & Community Workers Have No Counselling Qualifications

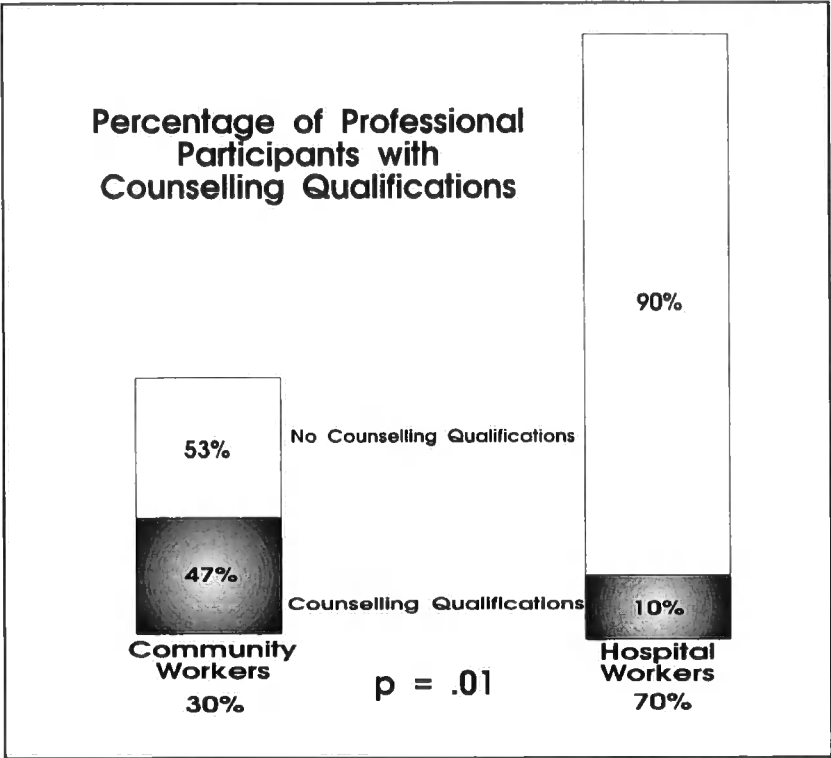


fig.3b 86% of Professional Questionnaire Respondents Were Midwives

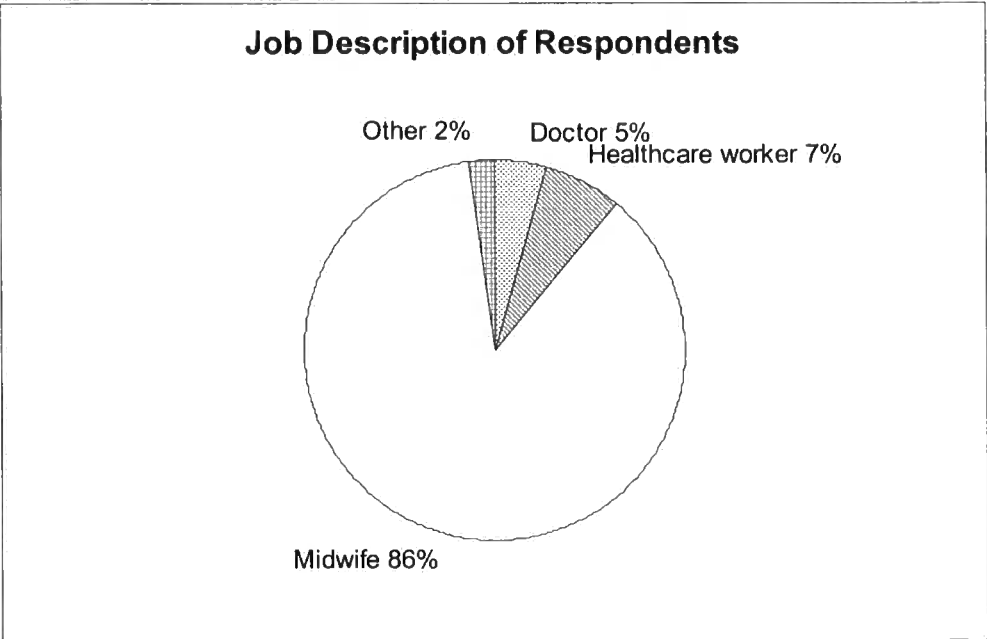


fig. 3c

Average Length of Employment at South Cleveland Hospital of Professional Questionnaire Respondents is 16 years

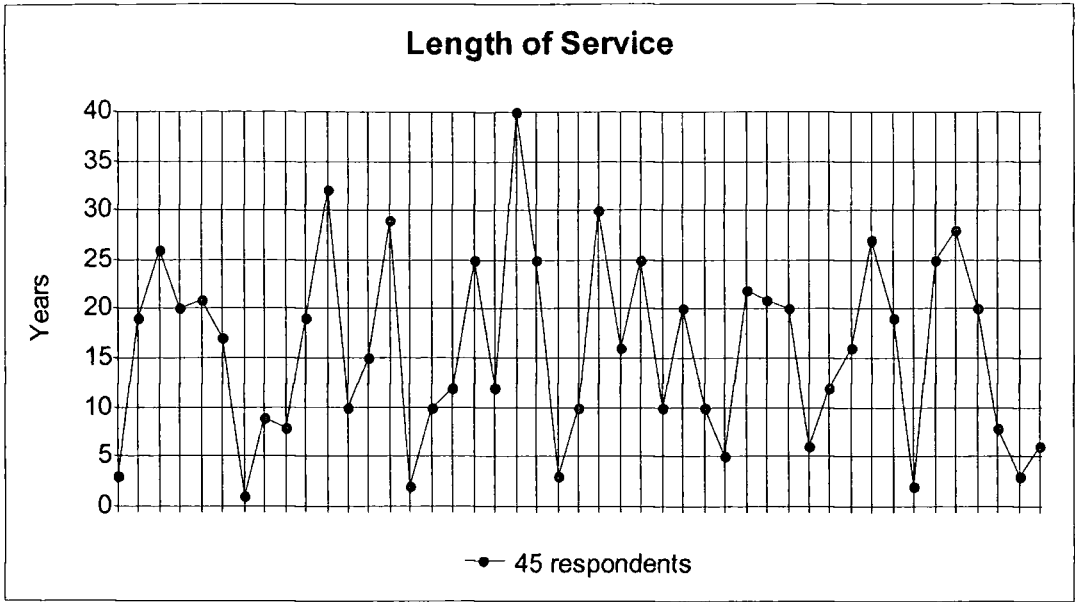


Fig 3d
Average Age of Professional Questionnaire Respondents is 41.16 Years

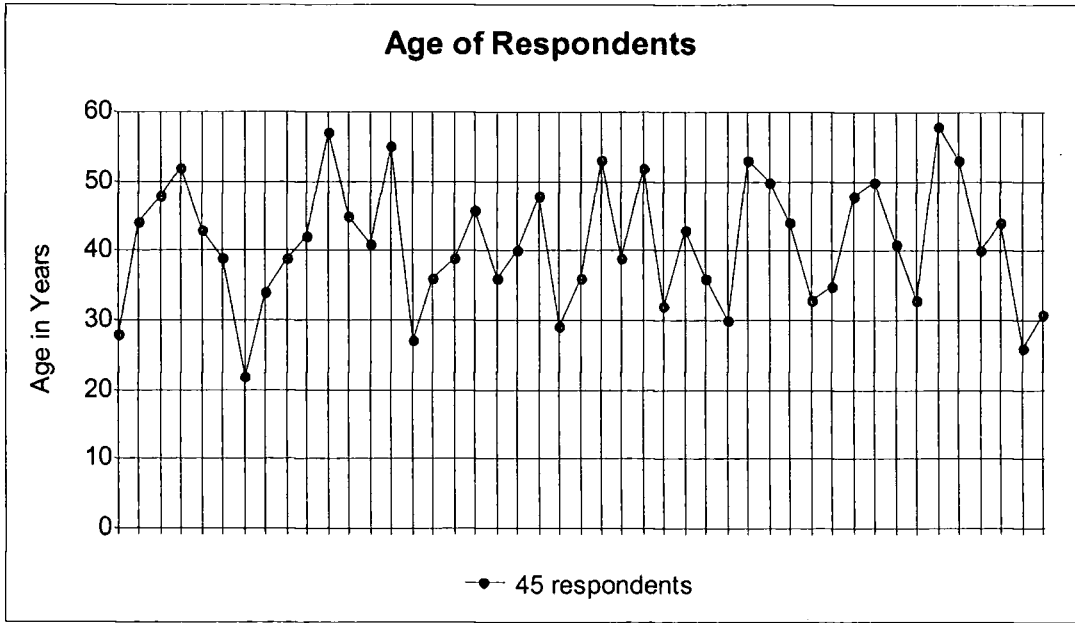


Fig. 3e
Professionals and Patients Agree That Following a Pregnancy Loss Counselling Should be Carried Out by a Midwife

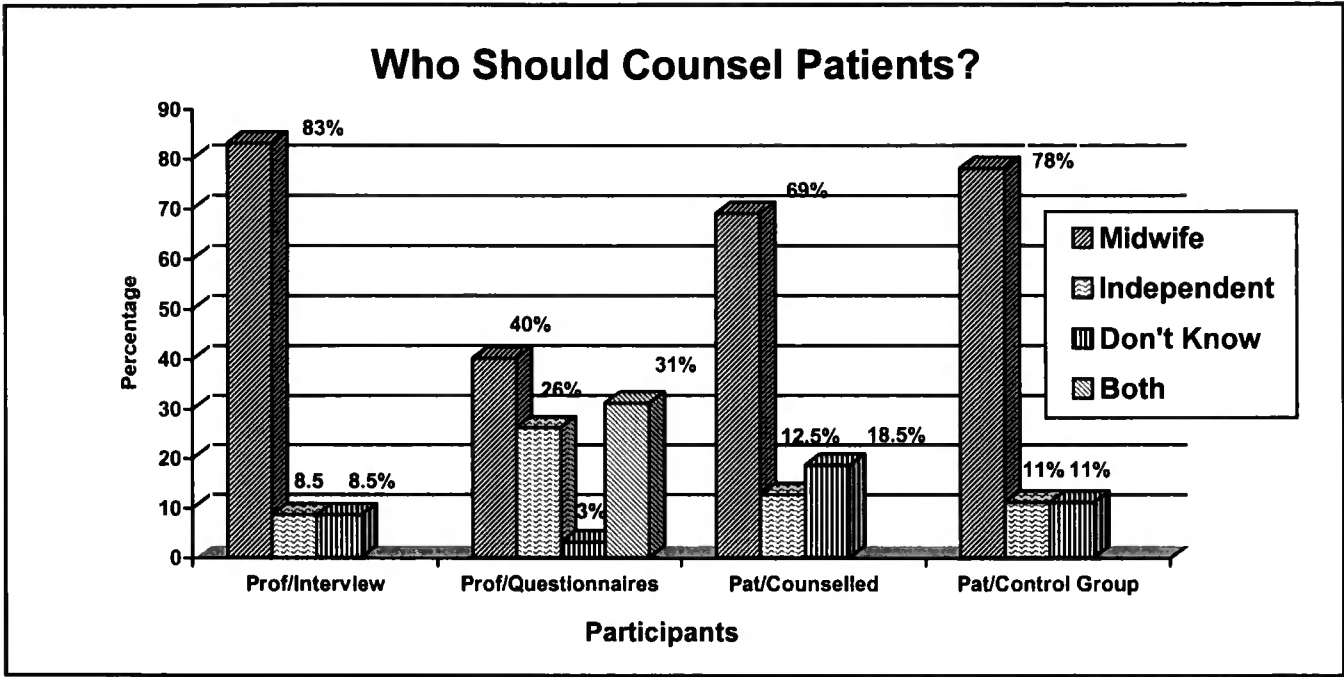


Fig. 3f
No Control Respondents Were Informed by a Midwife That Counselling Was Available

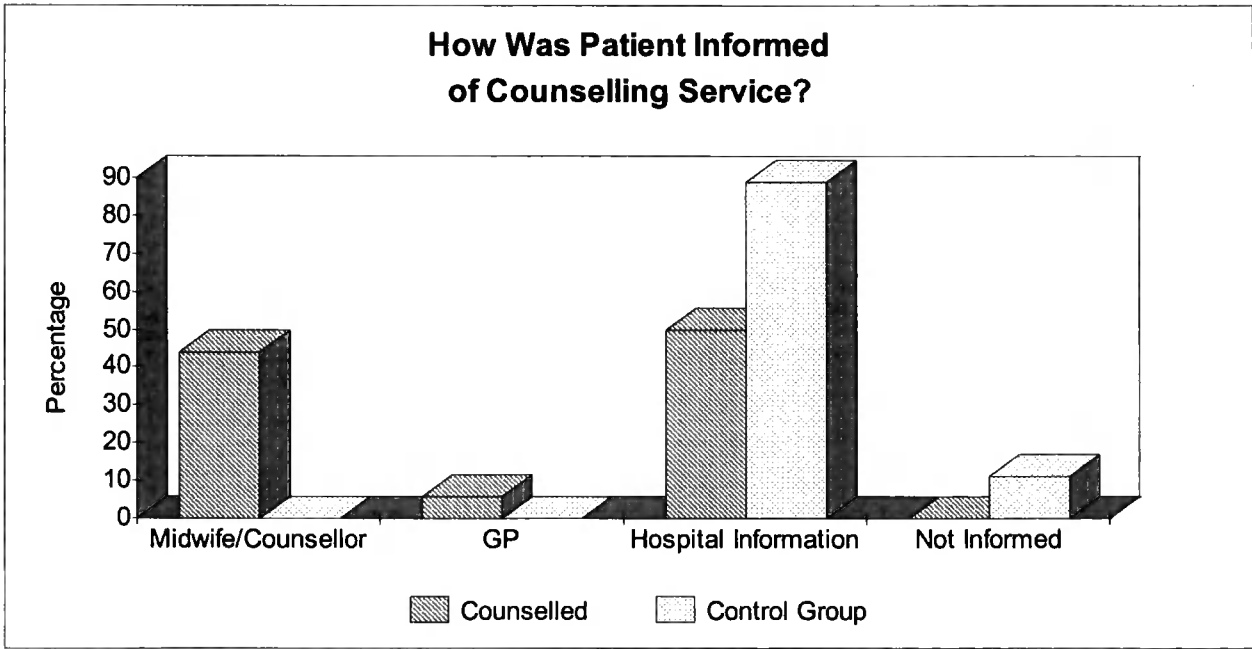


Fig.3g. 63% of Counselling Respondents Would Find it Difficult to Request Counselling

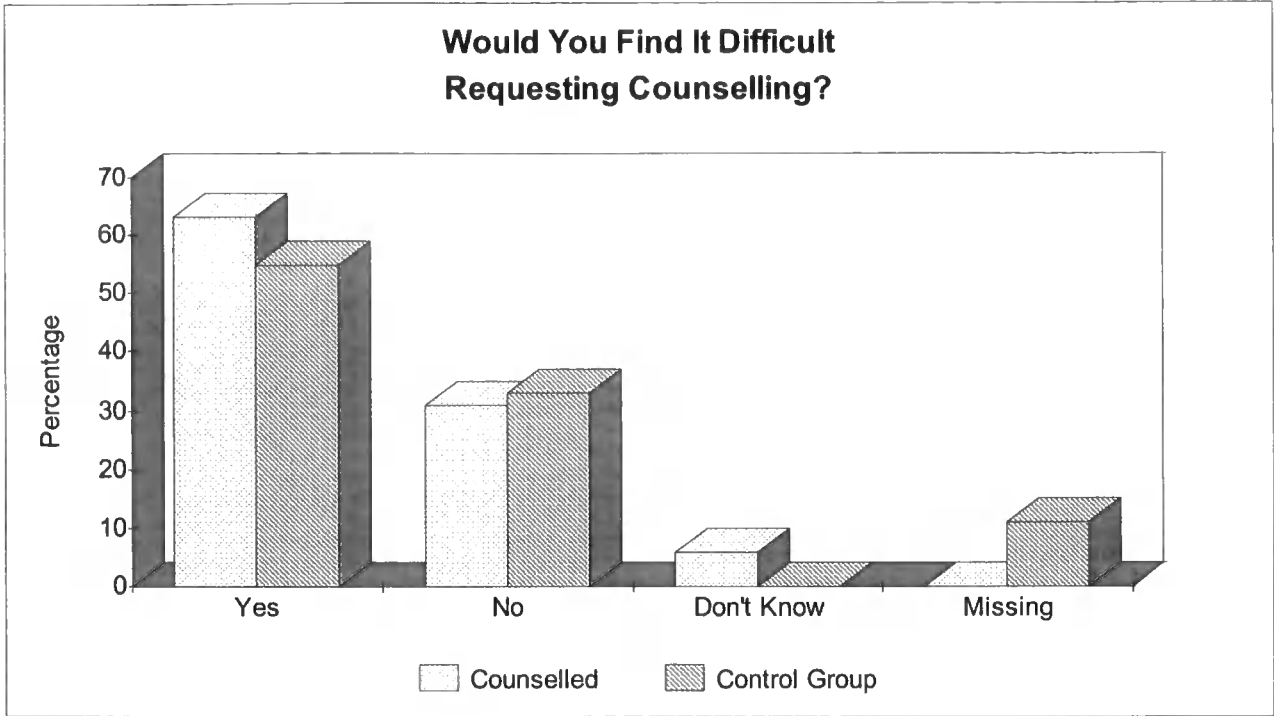


Fig. 3h
**In All Cases Where Counselling Sessions Were Terminated by the Counsellor
Respondent Thought They Should Have Received Counselling for a Longer Period**

No .	Was The Length of Time You Received Counselling Long Enough?	Who Terminated the Counselling Sessions?
1	yes	patient
2	no	midwife
3	yes	midwife
4	no	midwife
5	Don't know	patient
6	yes	patient
7	Still being counselled	n/a
8	yes	midwife
9	no	midwife
10	yes	midwife
11	no	midwife
12	yes	patient
13	yes	patient
14	yes	midwife
15	yes	patient
16	yes	patient

Fig.3i

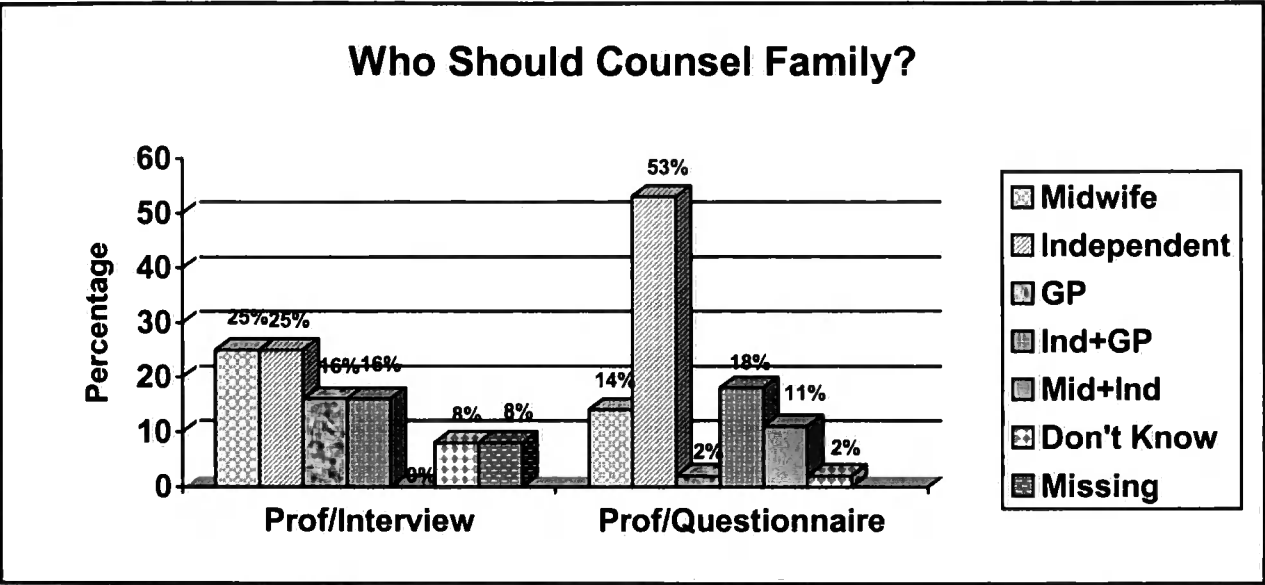


fig. 3j

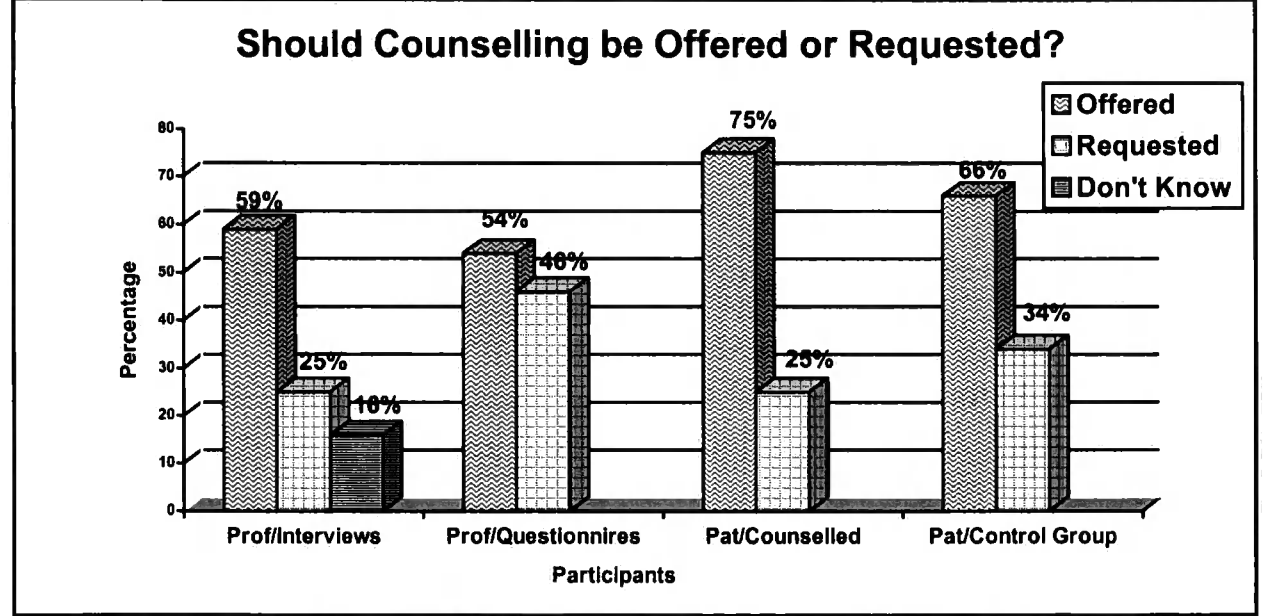


Fig. 3k
81% of Counselling Respondents Believed Their Grief Was Lessened by Counselling

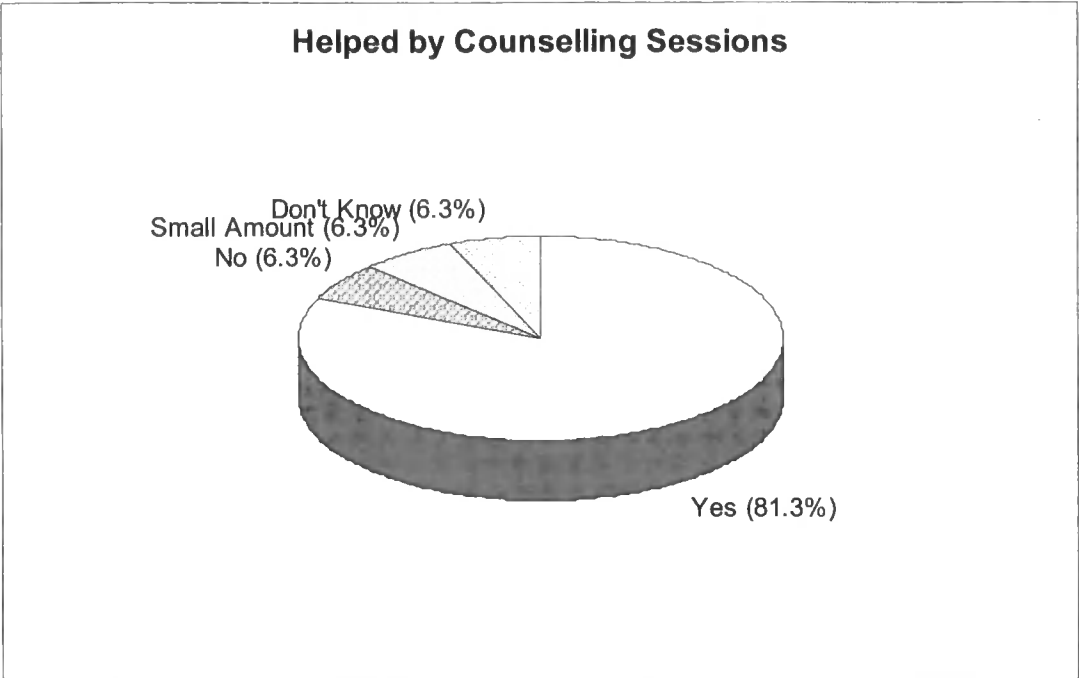


fig. 3l
44% of Control Respondents and 56% of Counselling Respondents Said the Hospital Should Have Given More Support During and After Their Loss.

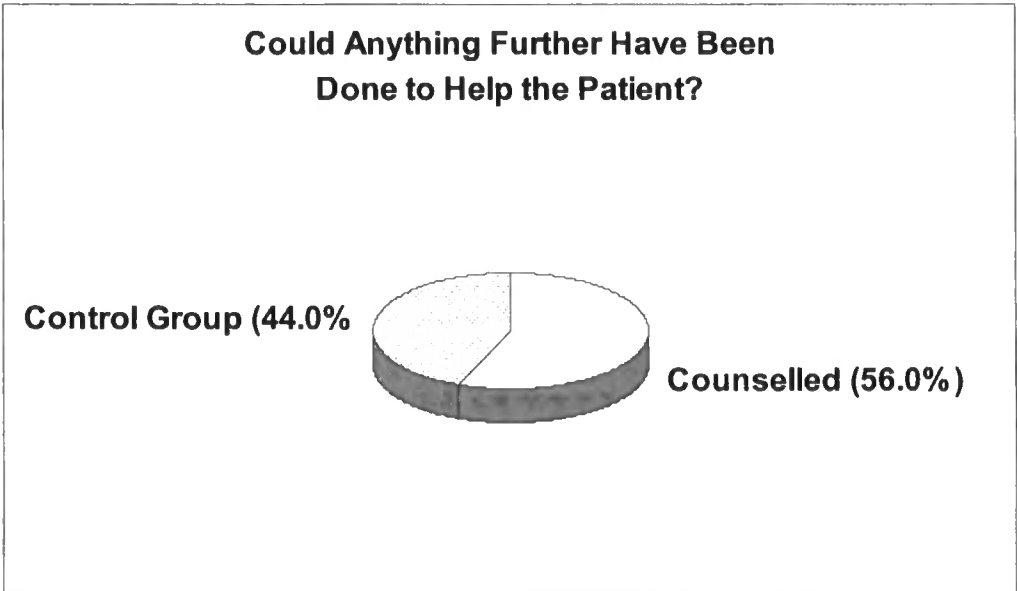


Fig.m

**73% of Control Respondents and 26% of Counselling Respondents
Had Strong Family Ties**

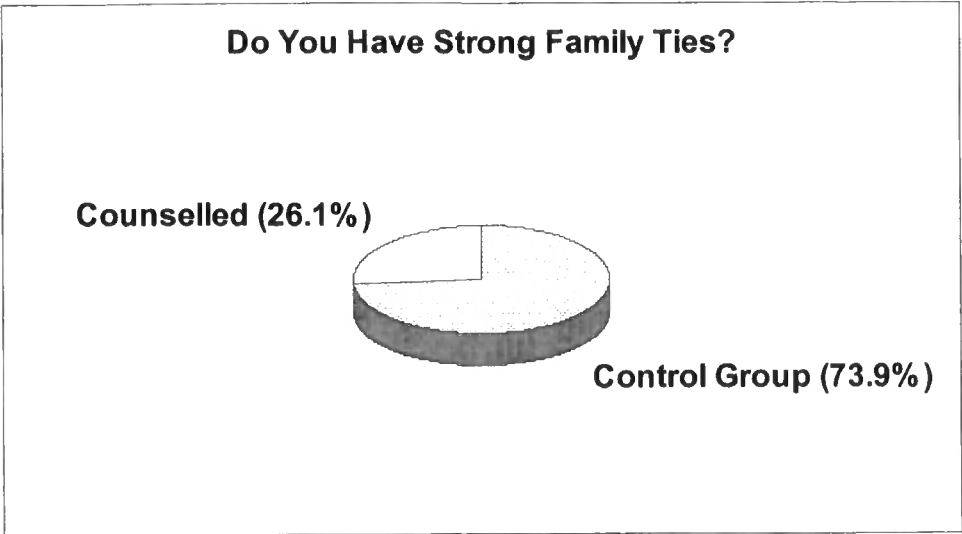


Fig. 3n

57% of All Respondents Were Adversely Affected by the Midwife's Uniform

